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ABSTRACT

The Minnesota 2-year state plan presents a review of the existing service delivery system for: (1) the provision of services to persons with developmental disabilities and their families; (2) a continuing response to priority areas specified in federal legislation; and (3) development of a work plan leading toward development of a Three-Year State Plan for the Fiscal Years 1992-1994. The first section considers the definition and impact of developmental disabilities including the federal definition, Minnesota's application of the federal definition, incidence of developmental disabilities, effects on individuals and families, and the Developmental Disabilities Basic State Grant Program. Section 2 describes the Governor's Planning Council on Developmental Disabilities and Section 3 describes the Administering Agency for the Developmental Disabilities Council. Considered in section 4 is the state context including program environment in Minnesota, scope of services, state review process, state plan review, review of other state plans, and statewide service system review. Plan revisions in the areas of priorities, goals, objectives, and budget data are examined in section 5. Nine attachments include a summary of public testimony, two policy analyses concerned with state hospitals and the Welsch consent decree, briefing books for Minnesota policymakers, and quality assurance publications. In addition to a list of 60 references and 12 audiovisual productions, there is an annotated bibliography of 50 recommended publications. (DB)

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TWO-YEAR TRANSITIONAL PLAN

STATE OF MINNESOTA DEVELOPMENTAL DISABILITIES

OCTOBER 1, 1989-SEPTEMBER 30, 1991

ED327048

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EC 232700

STATE OF MINNESOTA

TWO-YEAR TRANSITIONAL PLAN DEVELOPMENTAL DISABILITIES

Federal Fiscal Years 1990–1991
(October 1, 1989–September 30, 1991)

Submitted by:

Minnesota Governor's Planning Council
on Developmental Disabilities

Rudy Perpich
Governor

Lani Kawamura
Commissioner
Minnesota State Planning Agency

Roger Deneen
Chairperson
Minnesota Governor's Planning
Council on Developmental
Disabilities

This State Plan is a joint endeavor of the Minnesota Governor's Planning Council on Developmental Disabilities and the Minnesota State Planning Agency

PUBLISHED JANUARY 1990

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INTRODUCTION

This state plan is intended to meet the requirements as set forth by the Developmental Disabilities Assistance and Bill of Rights Act, Public Law (P.L.) 100-146, Part B, "Federal Assistance for Planning Priority Area Activities for Persons with Developmental Disabilities." Under this Act, federal funds are made available to states to assist in the development of a comprehensive system and a coordinated array of services and other assistance for persons with developmental disabilities. To receive federal funds under this Act, each state choosing to participate must submit a state plan. The plan, once approved by the Secretary of the Department of Health and Human Services, Washington, DC, provides the basis upon which a state will participate in programs and activities under Title I, Part B, of the Act.

The Two-Year Transitional State Plan is a state presentation of its review of the existing service delivery system for: (a) the provision of services to persons with developmental disabilities and their families; (b) a continuing response to priority areas (as specified in the Act); and (c) the development of a work plan leading toward the development of a Three-Year State Plan for the Fiscal Years 1992-1994.

A special thank you is extended to the members of the Minnesota Governor's Planning Council who have had the task of making difficult decisions and to the many state agency personnel who have provided the information needed to assemble this plan.

SECTION 1

Developmental Disabilities: Definition and Impact

1.1 What Are Developmental Disabilities?

"Developmental disabilities" are severe, chronic mental, and/or physical impairments which occur at an early age; are likely to continue indefinitely; and have a pervasive effect on an individual's functional abilities and need for services.

People with developmental disabilities are, first and foremost, people with ability. They are fundamentally more like the rest of the population than they are different from it. Without special assistance, however, some people with developmental disabilities cannot take advantage of the freedoms and opportunities of our society.

In Public Law 100-146, the Developmental Disabilities Assistance and Bill of Rights Act of 1987, Congress stated its findings as follows:

- There are more than two million persons with developmental disabilities in the United States;
- Individuals with disabilities occurring during their developmental period frequently have severe disabilities which are likely to continue indefinitely;
- Notwithstanding their severe disabilities, these persons have capabilities, competencies, and personal needs and preferences;
- Family and members of the community can play a central role in enhancing the lives of persons with developmental disabilities, especially when the family is provided with necessary support services;
- Persons with developmental disabilities and their families often require specialized lifelong assistance to be provided by many agencies in a coordinated manner;
- Agencies providing both generic and specialized services to persons with disabilities sometimes overlook or exclude these persons in their planning and delivery of services;
- Public and private employers tend to be unaware of the capability of persons with developmental disabilities to be engaged in competitive work in integrated settings;
- It is in the national interest to offer persons with developmental disabilities the maximum opportunity to make decisions for themselves and to live in typical homes and communities where they can exercise their full rights and responsibilities as citizens. [Section 101(a)]

1.1.1 The Federal Definition of Developmental Disability

Public Law 100-146, as amended, the Developmental Disabilities Assistance and Bill of Rights Act of 1987, defined a developmental disability as:

"A severe, chronic disability of a person which—

- is attributable to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the person attains age twenty-two;
- is likely to continue indefinitely;

- results in substantial functional limitations in three or more of the following areas of major life activity:

  self-care,

  receptive and expressive language,

  learning,

  mobility,

  self-direction,

  capacity for independent living, and

  economic self-sufficiency; and
- reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated." [Section 101(5)]

1.1.2
Minnesota's Application of the Federal Definition

The Governor's Planning Council on Developmental Disabilities uses the federal definition in its Request for Proposal and requires grant recipients to meet that definition in implementing grants.

1.2
How Many People Have Developmental Disabilities?

The population of persons with developmental disabilities in Minnesota is estimated at 68,912. This estimate is based on a prevalence rate of 1.6 percent of the state's 1988 population. The Minnesota Governor's Planning Council on Developmental Disabilities uses the 1.6 percent rate in estimating the population with developmental disabilities based on studies using categorical definitions and various studies of institutionalized and noninstitutionalized persons. This prevalence rate is also supported by the special report prepared by the Administration on Developmental Disabilities (ADD) on the impact resulting from the change in definition of developmental disabilities under Public Law 95-602, Section 202(6)(2) [ADD, May, 1981].

1.3
How Do Developmental Disabilities Affect Individuals, Their Families, and Their Communities?

Over the past 20 years, both society's view of people with disabilities and the help offered to individuals and their families have changed. Minnesota statutes and court decisions document the changes and show a long history of concern for people who are vulnerable. New principles call for more normal and less "institutional" program settings, integration with nondisabled people, and citizens participating in decisions about their lives. These changes are the result of a growing concern for individual rights, the effectiveness of advocacy groups, and the successes of people with disabilities in community programs.

Community programs have grown to provide alternatives to placement in large state-operated facilities. The mere **presence** of persons with disabilities in community settings, however, has come to mean a group home, a day program, paid staff, and limited integration opportunities. In contrast, **community**

participation, as described by Kiracofe (1985), can mean a real home, a real job, a real friend, and a real community:

> *A 'real home' is choosing to live where you want, with whom you want, and for as long as you want. . . A real home is an expression of the people who live there. . . A 'real job' is paid work, an opportunity to be productive, and make a contribution. It leads to self worth. . . A 'real friend' is a non-paid, non-professional companion, someone who chooses to spend time with you because they want to. . . Relationships that lead to friends, networks, and natural supports in the community are essential. The 'real community' is the natural community where all of us live, participate, and grow in. . . . The real community provides a sense of security in knowing that you belong. (pp. 6-7)*

People with developmental disabilities live, learn, and work in Minnesota communities with support from special programs and generic or existing services used by everyone.

Homes in the community should be family-sized, close to transportation and services, and provide individual attention to residents. For children with developmental disabilities, the first choice for a home is with their own families. The help families need is varied, often short-term, and far less costly than out-of-home care. In-home supports help keep families together. In Minnesota, some adults with developmental disabilities live in their own homes or are in Semi-Independent Living Services (SILS) where they learn skills they need to care for themselves. Several hundred adults and children live with foster families. Over 4,700 people live in community Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR). Residents of ICFs-MR must have a plan of care and 24-hour supervision.

Implementation of policies derived on an individual approach to providing services has resulted in a new set of residential, educational, and employment alternatives. These alternatives are detailed in Section 4.1.1.

1.4
What Is the Developmental Disabilities Basic State Grant Program?

The Developmental Disabilities Basic State Grant Program is a federally assisted state program designed:

- To assure that persons with developmental disabilities receive the services and other assistance and opportunities necessary to enable (them) to achieve their maximum potential through increased independence, productivity, and integration into the community; (and)
- To enhance the role of the family in assisting persons with developmental disabilities to achieve their maximum potential, [Section 102(b)]

The specific purpose of the Basic State Grant Program, as outlined in Section 121 of Public Law 100-146, is as follows:

- To assist (states) in the development of a comprehensive system and a coordinated array of services and other assistance for persons with developmental disabilities through the conduct of, and appropriate planning and coordination of, administrative activities, federal priority activities, and a state priority activity, in order to support persons with developmental disabilities to achieve their maximum potential through increased independence, productivity, and integration into the community.

The Governor's Planning Council on Developmental Disabilities

2.1 What Is the Governor's Planning Council on Developmental Disabilities?

The Minnesota Governor's Planning Council on Developmental Disabilities is a planning body composed of 27 members appointed for three year terms with a maximum of two consecutive terms. Each member is appointed by the Governor from among the residents of the state of Minnesota.

Membership Criteria: The Developmental Disabilities Act of 1987 (Section 204) required each state Council to include in its membership representatives of the principal state agencies, especially those agencies responsible for administering federal funds under:

- The Rehabilitation Act of 1973 (i.e., the Division of Rehabilitation Services of the Minnesota Department of Jobs and Training);
- The Education of All Handicapped Children Act (i.e., Special Education Section of the Minnesota Department of Education);
- Title XIX of the Social Security Act (i.e., the Minnesota Department of Human Services);
- Higher education training facilities and University Affiliated Program(s) (i.e., the Minnesota Institute on Community Integration at the University of Minnesota); and
- The state protection and advocacy system (i.e., the Minnesota Disability Law Center).

Other representation comes from local agencies, nongovernmental agencies, and groups concerned with services to persons with developmental disabilities.

At least 50 percent of the Council membership must consist of persons with developmental disabilities or parents or guardians of such persons. Of that 50 percent, one-third must be persons with developmental disabilities and another one-third must be immediate relatives or guardians of persons with mentally impairing developmental disabilities.

At least one individual must be an immediate relative or guardian of an institutionalized person with a developmental disability or a formerly institutionalized person.

The Council is charged with supervising the development of a state plan which describes the quality, extent, and scope of needed services provided to persons with developmental disabilities. The Council monitors and evaluates the implementation of the state plan, and reviews state services plans for persons with developmental disabilities. (Executive Order 87-9)

2.2 Who Are the Council Members?

Mr. Roger Deneen, Chair
Ms. Maribeth Ahrens
Ms. Anne Barnwell
Ms. Suzanne M. Dotson
Ms. Carolyn Elliott
Ms. Karen Gorr
Ms. Sharron Kathryn Hardy
Ms. Anne L. Henry
Ms. Linda Horkheimer
Ms. Paula H. Johnson
Ms. Michal Jorgens
Ms. Jeannette Kester
Ms. Toni Lippert
Ms. Virginia Marolt
Ms. Carolyn McKay, M.D.
Mr. Bill Niederloh
Ms. Mary O'Hara-Anderson
Ms. Nancy Okinow
Ms. Dorothy Peters, Ed.D.
Ms. Linda Rother
Ms. Janet M. Rubenstein
Mr. Tom Schwartz
Mr. Duane Shimpach
Mr. Edward R. Skarnulis, Ph.D
Ms. Lorrie Ufkin
Ms. Carol Werdin

The state provides assurance that federal membership requirements have been met.

SECTION 3

The Administering Agency for the Developmental Disabilities Program

3.1

What is the Designated State Administering Agency?

The designated state administering agency is the Minnesota State Planning Agency. The Developmental Disabilities Council, Human Services Division, is responsible for providing staff and other administrative assistance to the Governor's Planning Council on Developmental Disabilities. See Table 1.

3.2

Who Are the Staff Members?

The administering agency staff includes:

Colleen Wieck, Ph.D.
Executive Director. Ms. Wieck has a Doctor of Philosophy (Ph.D.) degree in educational psychology (special education). She has worked in the field of developmental disabilities for 17 years. She has served as executive director for the Minnesota Governor's Planning Council on Developmental Disabilities for the past eight years.

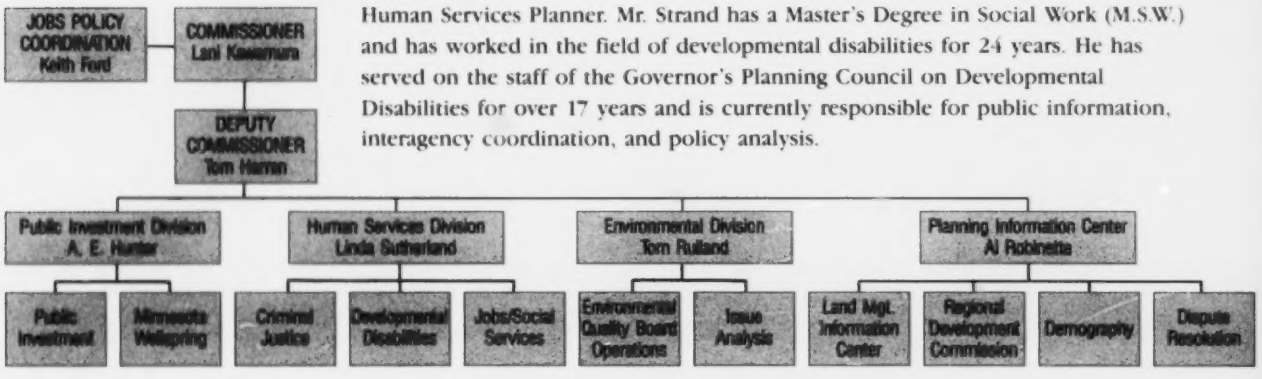
Audrey Clasemann
Office Coordinator. Ms. Clasemann has an Associate of Arts (A.A.) degree in graphic arts and specialized training in format editing and report typing (technical/statistical typing). She has been employed by the state of Minnesota for over 17 years and has been on the staff of the Governor's Planning Council on Developmental Disabilities for the past seven years.

RoseAnn Faber
Human Services Planner. Ms. Faber has a Master's of Social Work (M.S.W.) degree and has worked with the Minnesota Governor's Planning Council on Developmental Disabilities for almost 15 years. She is primarily responsible for legislative activities and for reviewing and making comments on proposed policies.

Ron Kaliszewski
Grants Administrator. Mr. Kaliszewski has a Master's of Science (M.S.) degree in community planning and has worked for the State of Minnesota for 25 years. He has been employed with the Minnesota Governor's Planning Council on Developmental Disabilities for almost eight years.

Roger Strand
Human Services Planner. Mr. Strand has a Master's Degree in Social Work (M.S.W.) and has worked in the field of developmental disabilities for 24 years. He has served on the staff of the Governor's Planning Council on Developmental Disabilities for over 17 years and is currently responsible for public information, interagency coordination, and policy analysis.

Table 1
Minnesota State Planning Agency



4.1
What Is the Environment in Which the Developmental Disabilities Program Operates in Minnesota?

The word "change" best describes Minnesota's service system for persons with developmental disabilities and their families. *A New Way of Thinking*, (1987), a publication by the Minnesota Governor's Planning Council on Developmental Disabilities, described the change:

> *Over the past several years, we have learned about people with developmental disabilities, what they are capable of doing, what is important in their lives, and how they can be supported in communities. From what we have learned we are changing our way of thinking and our way of acting. (p. 2)*

As observed by Toni Lippert who is a leading professional and Council member in the state, the following changes are occurring:

- A shift from expanding system capacity to increasing service quality.
- A move from fixed and predetermined expectations of persons with severe disabilities to higher and more demanding expectations by the individuals themselves, their families, and service providers.
- A move from short-term, developmental planning to life-long, functional planning.
- A move from providing a service continuum with emphasis on "special facilities and programs" to seeking a service array that adapts generic resources by providing the assistance and support as needed.
- A move from a fragmented grouping of separate and independent services (residential, day training, education) to recognition of the need for a holistic, interdependent and integrated service system.
- A move from a system of offering models of service delivery to one where it is possible to create individualized support.
- A move from service payment based on facility budgets toward reimbursement based on vendor performance and individual needs. (Toni Lippert, personal communication, 1986, in *A New Way of Thinking*, 1987, p. 2)

Recent events reflect such changes, as highlighted below:

Regional Treatment Center Negotiations: On July 28, 1988, the Minnesota Department of Human Services (DHS) issued a proposal which stated, "All persons with mental retardation or related conditions can be served in the community. . . It is time to identify the needed resources and plan for the placement of the remaining (1,494) persons into small, community-based homes."

By issuing the proposal, DHS sought to clarify the role of the Regional Treatment Centers over the next ten or more years, and to complete the process of moving persons with developmental disabilities into small community homes while retaining a role for the state in the delivery of services. The proposal was based on a major premise that Regional Treatment Centers should not be permanent homes. (*DD Information Exchange—State Supplement*, September 1988, p. 5)

Concurrently, the Commissioner of DHS established the Regional Treatment Center Negotiating Committee to determine the future role and function, if any, of the Regional Treatment Centers. This Committee concluded its work in March 1989, and soon thereafter, the 1989 Legislature acted on the proposal.

The final bill contained major provisions for people with developmental disabilities in the areas of community services, training and habilitation services, regional crisis management teams, Semi-Independent Living Services (SILS), Family Subsidy, and staff training. Total cost of the proposal is $13,452,000.

4.1.1

The Scope of Services for Persons with Developmental Disabilities

Services for persons with developmental disabilities are located in several state agencies. The state plans developed by these agencies were analyzed and a summary of common priorities is presented in Table 2. This table reflects only those state programs which have plans as required by state or federal governments. These plans serve as a possible guide for future interagency coordination and cooperation.

The following text describes state programs and the array of services available. State plans are summarized within the organizational context of the following agencies: (a) Institute on Community Integration, University of Minnesota; (b) Minnesota Department of Education; (c) Minnesota Department of Health; (d) Minnesota Department of Human Services; (e) Minnesota Department of Jobs and Training; (f) Minnesota Disability Law Center; (g) Office of the Ombudsman for Mental Health and Mental Retardation; (h) Social Security Administration; (i) State Board of Vocational Technical Education; and (j) State Council on Disability.

Table 2

Summary of Minnesota State Plans

(Reviewed April 1989)

PRIORITY AREAS IDENTIFIED IN STATE PLANS	MINNESOTA STATE PROGRAM									
	Department of Education, Special Education.	Department of Health, Maternal and Child Health.	Department of Human Services—Mental Health Division.	Department of Human Services—Developmental Disabilities Division.	Governor's Interagency Coordinating Council on Early Childhood Intervention.	Governor's Planning Council on Developmental Disabilities.	Legal Advocacy for Persons with Developmental Disabilities.	Minnesota Board on Aging.	Minnesota Department of Jobs and Training: Division of Rehabilitation Services and Supported Employment Project.	State Board of Vocational-Technical Education.
Early Intervention/Prevention:										
• Prenatal care/infant mortality		X			X					
• Consumer/parent/public information	X	X	X		X	X	X			
• Family planning		X								
• Family support services, e.g., respite care	X	X	X		X					
• Health/mental health curriculum	X	X	X							
• Teenage pregnancies		X			X					
• Safety education		X								
• Environmental quality		X								
Employment/Habilitation:										
• Work preparation and placement				X		X			X	X
• Transition from school to work	X			X		X			X	X
• Increase employment opportunities				X		X		X	X	X
• Supported employment			X	X		X			X	
Community Living/Integration:										
• Independent living				X		X		X	X	
• Housing				X			X	X	X	
• Accessibility									X	
• Assessment/relocation/inappropriate placements/ deinstitutionalization				X		X	X	X		
• Least restrictive environment/education	X					X	X		X	
Quality and Quantity of Services:										
• Children/adolescents (general)	X	X	X	X	X	X			X	
• Mental health/children	X		X							
• Mental health/adults			X					X		
• Technological applications	X					X			X	
• Licensure/monitor quality	X		X	X	X			X		X
Administrative Services:										
• Improve administrative efficiency		X		X		X	X		X	
• Interagency coordination	X	X	X	X	X	X	X	X	X	X
• Personnel training	X			X	X	X	X	X	X	X
• Technical assistance	X			X		X	X	X	X	
• Policy reform, legislation/regulations	X		X	X		X	X	X	X	
• Information systems/evaluation	X		X			X		X	X	
• Local comprehensive planning		X	X			X	X	X	X	
• Case management/guidance services			X	X	X	X		X	X	X
Advocacy/Protection of Rights:										
• Protective services		X	X	X			X	X		
• Legal services				X				X	X	
• Affirmative action/employment discrimination			X				X		X	
• Consumer empowerment/accountability/self-advocacy						X	X	X		

Institute on Community Integration

The Institute on Community Integration (a University Affiliated Program on Developmental Disabilities) was established in February 1985 to provide interdisciplinary training, exemplary services, and information for Minnesota citizens with developmental disabilities, their families, service providers, and communities. The Institute, located at the University of Minnesota, joins a network of University Affiliated Programs across the United States.

Program priorities are reviewed by both faculty and community advisory committees. Close working relationships exist with the Minnesota Governor's Planning Council on Developmental Disabilities and other state agencies.

The mission of the Institute is to:

- Maximize the opportunity of citizens with developmental disabilities to experience the benefits of family and community living while receiving services needed to develop their full potential for personal independence, self-care, and social participation; and
- Improve the quality and community orientation of professional services and social support to persons with developmental disabilities and their families.

Interdisciplinary Training: A major program emphasis of the Institute is interdisciplinary training. Formal coursework is available to students who have not yet started their careers. Placement services are provided to help students in a variety of disciplines acquire relevant experience in working with individuals with developmental disabilities. In-service training is available for those who are already working with individuals with developmental disabilites but who want to update or add to their skills. Conferences of interest to parents and family members, service providers, and policymakers are also provided.

In 1989, there were 765 students receiving interdisciplinary training at the Institute. Over 5,000 parents, consumers, and service providers received in-service training from Institute personnel.

Exemplary Services and Technical Assistance: The Institute provides exemplary services and technical assistance through numerous community programs. Several areas are emphasized:

- Developing, evaluating, and disseminating new and effective community service interventions;
- Improving the capacity of existing community agencies to provide appropriate integrated services to people with developmental disabilities;
- Working with legislators and agency administrators to establish and refine the type, amount, and quality of services provided to persons with developmental disabilities with the goal of achieving the highest possible level of community integration.

In 1989, there were 894 people with developmental disabilities receiving services through the Institute's community programs.

Information, Dissemination, and Research Systems: The Institute integrates information, dissemination, and research systems into both training and exemplary services by:

- Addressing the concerns of personnel who provide direct services to persons with developmental disabilities;
- Providing researchers and government agencies with information for further training and service related research; and
- Improving the flow of information within the UAP network and for use in Minnesota.

Minnesota Department of Education

Special Education Services

Unique Learner Needs Section: This state agency, a division of Instructional Effectiveness, Department of Education, is responsible for providing special education services to students with handicaps (birth through age 21).

Authority for the provision of special education services includes, but is not limited to: (1) the Education of All Handicapped Children Act; (2) Minnesota Statutes 120.03, 120.17 and 124.32; and (3) State Board of Education Rules Chapter 3525.

Funding for special education programs is provided through state, local, and federal sources. Total expenditures in 1987-1988 for special education services totaled $310,798,000 (which includes costs of early childhood education), a substantial increase when compared to 1979-1980 expenditures of $147,552,000. Table 3 provides a breakdown by sources of revenue and compares levels of expenditures between 1979-1980 and 1987-1988. While state and federal levels of participation decreased over this period, local school districts increased their levels of participation from 29.6 percent to 39.0 percent of the total expenditures. (Minnesota Department of Education, 1989, pp. 2-3)

During the 1988-89 school year, 82,647 students (birth through age 21) received special education services from local education agencies (LEAs). See Table 4.

Secondary Vocational Education Services: The Secondary Vocational Education Unit of the Minnesota Department of Education is the state agency responsible for administering vocational education programs. State law requires that federal vocational funds for students with handicaps must be added to the state allocation. These federal funds are distributed to local education agencies (LEAs) on a formula basis. LEAs apply annually for program and funding approval to provide special vocational education programs and services to students with disabilities who require: a modified vocational education program, a specially designed vocational program, and/or are in need of special vocational educational assistance. The students who receive these services must have one or more handicapping conditions as defined by the Special Education Section of the Minnesota Department of Education.

Least Restrictive Environment: According to the *Tenth Annual Report to Congress on the Implementation of the Education of the Handicapped Act* (U.S. Department of Education, 1988), Minnesota served a higher proportion of students in resource rooms and in separate facilities or institutions than the respective

national averages, during the school year 1985-1986. Table 5 demonstrates that Minnesota served a lower proportion of students with handicaps in regular classrooms and in separate classes than the respective national averages. (Minnesota Department of Education, January 1989, pp. 48-49)

Another national report (Danielson & Bellamy, 1989), compared states in terms of the placement rate for students with handicaps in separate schools and residential facilities. Minnesota ranked tenth from the bottom among those states having the greatest number of children with disabilities in the most segregated settings. Those states that ranked even lower than Minnesota (in descending order) were: Connecticut, New Jersey, Ohio, New York, Maryland, Maine, Delaware, and Washington, DC. Minnesota placed twentieth on another scale that compared placement rates for students with disabilities in separate classes, separate schools, and residential facilites. Oregon had the highest degree of integration in their schools on both scales.

Table 3
Comparison of Special Education Expenditures:
1979-1980 and 1987-1988*

	EXPENDITURES			
	1979-1980		1987-1988	
SOURCES OF REVENUE	Amount	Percent	Amount	Percent
Local:	$ 43,727,000	29.6%	$120,825,000	39.0%
• Local Pro-rated			9,876,000	3.3%
State Aid (Regular):	86,788,000	58.8%	151,283,000	48.7%
• State/Summer School	4,134,000	2.8%	5,271,000	1.7%
Federal:				
• (Including Summer School)	12,903,000	8.8%	22,798,000	7.3%
TOTAL	$147,552,000	100.0%	$310,053,000	100.0%

Source: Minnesota Department of Education (1989, January), pp. 2-3)

*These amounts include Early Childhood Education

Table 4

Unduplicated Child Count: Number of Children and Youth Receiving Special Education and Related Services in Minnesota by Age Category and Primary Disability in School Year 1988-1989

	AGES								
PRIMARY DISABILITY	Birth-2	3-5	6-8	9-11	12-14	15-17	18-21	Over 21	TOTAL
Speech Impairment	150	3,235	7,518	4,716	1,075	387	33	0	17,114
Educable Mental Retardation	31	144	1,330	1,685	1,745	1,879	606	5	7,425
Trainable Mental Retardation	11	159	498	564	567	648	743	15	3,205
Physical Handicaps	41	155	381	319	220	188	50	1	1,355
Hearing Impairment	57	149	312	354	251	214	45	0	1,382
Visual Handicaps	13	40	81	71	67	82	12	0	366
Learning Disabilities	2	121	5,296	10,737	9,551	7,988	1,108	2	34,805
Emotionally Impaired	2	88	1,136	2,015	3,270	3,682	487	3	10,683
Deaf/Blind	1	7	7	5	3	1	4	1	29
Other Health Impairments	18	36	117	90	83	77	11	0	432
Autistic	3	20	36	46	30	15	21	1	172
Early Childhood	1,195	4,289	195	0	0	0	0	0	5,679
TOTAL	1,524	8,443	16,907	20,602	16,862	15,161	3,120	28	82,647

Source: Minnesota Department of Education (1988, December 1).

Table 5

Comparison of Minnesota vs. National Averages: Special Educational Environments for Students 3-21 Years Old School Year 1985-1986

SPECIAL EDUCATION ENVIRONMENT	MINNESOTA	NATIONAL
Regular Classroom	12.62%	26.24%
Resource Room	62.69%	41.40%
Separate Classes	9.83%	24.49%
Public Separate Facility	12.28%	3.79%
Private Separate Facility	0.00%	1.64%
Public Residential Facility	0.47%	0.97%
Correctional Facility	0.03%	0.31%
Homebound/Hospice	2.08%	0.79%

Source: Minnesota Department of Education (1989, January), pp. 48-49.

Special Education State Plan: The major goal of this plan is to provide full educational opportunities to all children with disabilities in Minnesota from birth through age 21. The plan describes how the State Education Agency (SEA) will use Public Law 94-142, Part B funds to accomplish the following:

- Assist local education agencies (LEAs) in ensuring that children and youth with disabilities are provided with free, appropriate education.
- Monitor LEAs for program compliance.
- Inform parents of their child/youth's rights to appropriate public education.
- Direct and assist the local identification of children and youth with disabilities.
- Assist LEAs in developing individualized education programs appropriate to the needs of children and youth with disabilities.
- Accept and respond to formal written complaints from parents of children and youth with disabilities.
- Assure that the requirements of the least restrictive environment (LRE) are met in educational programs for children and youth with disabilities.
- Assure that testing, materials, and procedures used to assess children and youth with disabilities are not racially or culturally discriminatory, and that a full needs assessment is conducted prior to the placement of a child/youth in a special education program.
- Establish a range of training opportunities that offer professional growth and foster communication and collaboration among educators of children and youth with disabilities.
- It is the responsibility of the LEA to assure and ascertain that children and youth residing in the district receive the education, related services, and rights to which they are entitled.

Five percent of Public Law 94-142, Part B funds will be used for the activities outlined above. At least 75 percent of the Public Law 94-142, Part B Funds will be used for projects of local districts or cooperatives —"flow through" projects. The difference between monies used for administration and "flow through" projects will be used for discretionary grants.

Interagency Office on Transition Services

As authorized by the 1985 Minnesota Legislature, the Department of Education established an Interagency Office on Transition Services. The purpose of this statewide program is to address the needs of students with disabilities as they progress through school and enter postsecondary training, employment, and community living.

Some of the responsibilities of this office include:

- Provide staff to the State Transition Interagency Committee, which is made up of representatives from special education, rehabilitation services, vocational education, human services, postsecondary education, consumers/advocates, and developmental disabilities;
- Coordinate personnel training and develop in-service training programs;
- Provide information, consultation, and technical assistance to state and local agencies about transition services;
- Assist agencies in establishing local interagency agreements to assure efficient and appropriate transition from school to work or postsecondary training programs; and
- Gather and coordinate data on transition services for secondary-age students with disabilities.

Transition—The Need: One of the most important questions that public schools are beginning to address is what happens to youth with disabilities after they complete their special education program. A national study conducted by Louis Harris and Associates (1986) stated:

> *Not working is perhaps the truest definition of what it means to be disabled:two-thirds of all disabled Americans between the ages of 16 and 64 are not working. . .Sixty-six percent of working-age disabled persons, who are not working, say that they would like to have a job. . .The challenge is how society can effect policies and programs which will bring more disabled persons into the working mainstream. . .(p. 4).*

Results from a Minnesota Post-School Follow-Up Study (1984-1987) regarding the community experiences of over 400 former special education students point out several concerns:

- Only 9 percent of former students with moderate/severe disabilities had full-time paid employment; another 28 percent had part-time employment.
- Most people with moderate/severe disabilities interviewed lived in group home residential placements (59 percent).
- A main concern reported by former students is loneliness—few have friends, most spend a lot of time watching TV and most have a minimal social life.
- Parents had significant concerns about what will happen to their children when they can no longer care for them.
- Fifty-one percent of the parents reported that services related to the post-school needs of their son/daughter were not being discussed with them.
- Fifty-two percent of the parents communicated that they were not familiar with the types of community services available for their son/daughter following the transition from school. (Minnesota Department of Education, 1987, p. 2)

Table 6 summarizes the estimated number of students ages 17 and over who have exited special education services between 1986 and 1988. Of the approximately 7,659 to 7,830 students leaving school, at least 4,000 (51 percent) had substantial disabilities. This population will most likely need further intensive and follow-along services from the adult service system. (Minnesota Department of Education, *Unduplicated Child Counts*, 1986 through 1988).

Table 6
Estimated Number of Students Who Leave Special Education in Minnesota: 1986-1988

(Ages 17 and Over)

YEAR	TOTAL NUMBER LEAVING SPECIAL EDUCATION	NUMBER LEAVING WHO HAVE SUBSTANTIAL DISABILITIES[a]
1986	7,659	3,913
1987	7,890	4,024
1988	7,830	4,001

Source: Minnesota Department of Education, *Unduplicated Child Counts*, 1986 through 1988.

[a]This number includes students with mental retardation, physical disabilities, hearing impairments, visual handicaps, autism, and those who are deaf and blind, emotionally disturbed, or have other health impairments. This number excludes the number of students with more mild types of disabilities such as learning disabilities (which comprise approximately 45 percent of the total special education population) and speech impairments (20.0 percent).

Transition—Meeting the Challenge: Transition from special education to secondary vocational education and postsecondary education, training, employment, and community living has been established as a priority of the Minnesota Department of Education. Several mechanisms are now in place to meet the challenge:

- The *Minnesota Interagency Cooperative Agreement to Plan* was signed in December 1987 by those participating on the State Transition Interagency Committee consisting of 11 state agencies, a coalition of parents, and an advocacy organization.
- State legislation was passed requiring that each student's transition needs be addressed in the Individual Education Plan (IEP) starting at age 14 or in the ninth grade.
- Under a state legislative mandate, 70 Community Transition Interagency Committees have been established to coordinate local transition efforts.
- Several technical assistance projects sponsored by the Minnesota Department of Education and Interagency Office on Transition Services are housed at the Institute on Community Integration, University of Minnesota. These projects address: (a)the formation and support of the Community Transition Interagency Committees; and (b) the development of a follow-up data system for local school districts that will provide statistical information that answers the question of what happens to youth with disabilities after they leave high school.

Early Childhood Special Education

In 1986, Minnesota local school districts were mandated by the Legislature to serve all eligible children with disabilities, beginning at birth. This mandate was implemented July 1, 1988. During the 1988-89 school year, 9,967 children from birth through age five were served by local educational agencies.

The rationale for early intervention services is based on developmental and psychological research which indicates:

- Human behavior at any point represents a series of elaborations of previous behavior from simple to complex beginning at birth.
- The acquisition of motor, cognitive, and language skills is interrelated.
- Social behaviors are learned as early as infancy.
- Failure to learn may also begin at birth.

The framework for providing statewide early intervention services for children with disabilities, or children who are at risk of developing disabilities, and their families consists of the following components:

- The Lead Agency—Minnesota Department of Education;
- State Agency Committee;
- Governor's Interagency Coordinating Council on EarlyChildhood Intervention;
- Interagency Early Intervention Committees; and
- Regional Early Childhood Coordinators.

Lead Agency: Designated by the Governor in 1987, the Minnesota Department of Education serves as the lead agency in developing a comprehensive interagency early intervention service system, in accordance with federal Public Law 99-457 (Part H). The Department of Education has the responsibility for the general administration, supervision, and monitoring of programs and activities relating to early intervention services.

State Agency Committee: This Committee consists of the Lead Agency and the Department of Human Services and Health. In conjunction with the other members of the State Agency Committee, the Minnesota Department of Education is responsible for the identification and coordination of resources, assignment of financial responsibility, development of procedures to ensure timely service, resolution of intra- interagency disputes, and entering into formal interagency agreements. The respective agency commissioners signed agreements in 1984 and 1987 reaffirming support for interagency collaboration in comprehensive planning for early intervention services. The current interagency agreement addresses public awareness activities, interdisciplinary approaches, interagency problem solving, development of screening and assessment program models, coordination of services, and the implementation of state and federal initiatives.

Governor's Interagency Coordinating Council on Early Childhood Intervention: Created in 1989, this Council advises and assists the Minnesota Department of Education and recommends policies to the Governor, Legislature, State Agency Committee, and other departments. Members are appointed by the Governor, in accordance with Minnesota Statutes 120.17, to meet the requirements of federal legislation under Part H of Public Law 99-457. Representation on the council includes: parents of children with disabilities under age seven, public and private providers, teacher preparation program in early childhood special education, advocacy organizations, early childhood special education teachers, one member from each state legislative body, State Agency Committee representatives, and others knowledgeable about young children with disabilities.

Interagency Early Intervention Committees (IEICs): Established in 1985 under Minnesota Statutes 120.17, there are 98 Community IEICs currently operating at the local level. Duties include: identifying services and funding sources; establishing and evaluating identification, referral, and intervention services; facilitating the development of interagency coordination, especially for individual educational and transitional plans; recommending assignment of financial responsibility; and reviewing school district and county health and human service plans.

Regional Early Childhood Coordinators: Ten Regional Coordinators assist school districts, other public and private providers of services, and families. Duties include: increase public awareness of the need for coordinated services; provide technical assistance regarding screening, referral, assessment, intervention, evaluation, and procedural safeguards; and develop model interdisciplinary approaches to early intervention services.

State Plan Goals for Early Childhood Special Education include:

- Increase the quality and quantity of services available to children, birth through five years of age; improve strategies to identify, locate, and evaluate all children with disabilities, birth through five years of age;
- Improve administrative supports to maximize services to these children;
- Train parents in child development and the special needs of their children with disabilities through interagency cooperation with the departments of Health and Human Services;
- Promote the development of comprehensive services for children with disabilities from birth; and
- Improve the transition of young children with disabilities into kindergarten.

Early Childhood State Plan Objectives 1988-1989:

- Develop a statewide policy that includes strategies to ensure that appropriate early intervention services will be available to all infants and toddlers with disabilities or those at risk and their families.
- Coordinate the provision of early intervention services for young children with disabilities and their families in local communities throughout the state through grants and technical assistance.
- Increase public awareness, advocacy and coordinated interagency systems through the dissemination of materials and technical assistance to policymakers, providers, and parents.
- Develop an evaluation system to monitor the impact of the state plan for young children with disabilities and their families. (Minnesota Department of Education, 1988.)

Community Education

Community Education programs are available in 95 percent of all public school districts in Minnesota. Community Education provides an opportunity for local citizens, community schools, agencies, and organizations to become active partners in addressing education and community concerns. The purpose of Community Education is to make maximum use of a community's human resources by the schools. Through community education, community members have the opportunity to link community needs and resources. The quality of life in a community is enhanced by lifelong learning for all citizens. Most common components include early childhood development, family education, adult basic education, and youth development planning.

In 1989, 62 communities focused on adults with disabilities. These community education programs were supported through state grants up to $30,000 which were matched with local funding. Common goals included supporting and enhancing the role of adults with disabilities so that they can participate more fully in community education activities.

Minnesota Department of Health

Community Health Services (CHS)

Created by the Minnesota Legislature in 1976, the Community Health Services Act provides for the development and maintenance of an integrated system of community health service operated under local administration. CHS protect and improve the health of people within a geographically defined community by emphasizing services to prevent illness, disease, and disability. This is accomplished by promoting effective coordination and use of community resources and by extending health services into the community.

All 87 counties in Minnesota are participating in the Community Health Services System through 47 locally administered Community Health Boards who work in partnership with the Department of Health. Services include: Disease Prevention and Control, Community Emergency Medical Services, Environmental Health, Community Nursing and Maternal and Child Health, Health Education, and Home Health Care. Programs are financed by a combination of state, local, and federal funds. Total expenditures have grown from $35 million in 1977 to over $119 million, of which $91 million (over 75 percent) represents local participation in Community Health Services funding. (See Table 7) (Minnesota Department of Health, 1989, p.11)

Table 7
Program Expenditures for Community Health Services in 1987

Program	Amount	Percent
Community Nursing and Maternal and Child Health[a]	$ 30,984,829	26.0%
Home Health	$ 34,739,294	29.2
Disease Prevention and Control	$ 6,680,460	5.6
Emergency Medical Services	$ 20,274,827	17.0
Health Education	$ 1,896,626	1.6
Environmental Health	$ 15,822,511	13.3
Other[b]	$ 8,679,339	7.3
TOTAL	$119,077,886	100.0%

[a]Includes expenditures for Women, Infants, and Children (WIC) amounting to $3,650,580.

[b] "Other" program expenditures include grants for Native American Health, Migrants, Administration, and other expenditures not specific to a statutory program category.

Maternal and Child Health Services

The purpose of Maternal and Child Health Services is to improve the health status of children and youth, women, and their families by providing technical and financial support services to local community health agencies, schools, and voluntary organizations. Services include program planning, goal setting, technical consultation, professional education and training, and grants for specialized purposes. These activities are used in combination at the service delivery site so that comprehensive Maternal and Child Health Services are provided to individuals.

Clinical services provided in local health agencies and schools include infant and child health assessment, health maintenance services such as immunizations, health promotion, general health screening, Early and Periodic Screening, Early Childhood Health and Developmental Screening, hearing and vision screening, scoliosis screening, and screening for elevated levels of lead. An assessment was made through surveys conducted in 1987-1988 by the Minnesota Department of Health revealing high levels of immunizations among school-age children (Kindergarten through Grade 12): diphtheria, tetanus, and pertussis (99.1 percent); polio (99.2 percent); measles (99.4 percent); mumps (99.0 percent); and rubella (99.5 percent) (Minnesota Department of Health, 1989, p. 39).

In 1987, there were 95,268 people served through clinical services provided by the Community Health Services Agencies: 42,014 people receiving family planning services; 27,534 in clinics serving infants and children; 13,957 in maternity clinics; 6,073 in Early and Periodic Screening clinics, and 5,690 served by screening for elevated levels of lead (Minnesota Department of Health, 1989, p.30).

The **Special Supplemental Food Program for Women, Infants,and Children (WIC),** funded through the U.S. Department of Agriculture, provides nutritious supplemental foods and nutrition education to mothers of infants and children (up to age five) who are at nutritional risk and enrolled in local WIC programs. Participants receive vouchers for purchase of specified foods at authorized grocery stores.

The **Human Genetics** program provides counseling for patients and family members with known or suspected genetic diseases, consultation, education, and diagnostic support to physicians and other health professionals, and detection of metabolic diseases in newborns through screening. These services help persons manage genetic diseases and make informed decisions about family planning.

The purpose of the **Child Health Screening, Health Promotion Unit** is to provide technical support for high quality and accessible health and developmental screening for all children in the state. Services are supported by combined state and federal funds provided through the state departments of Health, Education, and Human Services, and administered in communities.

Services for Children with Handicaps (SCH) provides for the identification, diagnosis, and treatment of children with handicapping conditions caused by birth defects, congenital cardiac lesions, hereditary disease, or chronic diseases such as diabetes, cystic fibrosis, or cancer. In Fiscal Year 1988, SCH conducted approximately 217 field clinics throughout Minnesota, serving 6,919 children. Efforts are made to ensure that children receiving benefits under the Supplemental Security Income (SSI) Program are aware of services available to them through the SCH program. SCH offers leadership in establishing guidelines and serves as a model for a system of multispecialty care for children with disabilities.

The **Hearing and Vision Conservation** activity assures that children with hearing or vision problems are identified at the earliest possible time and arrangements made for treatment and remediation. This activity is accomplished by local and regional personnel using state guidelines, technical consultation and training, and equipment calibration to assure quality service and cost-efficiency. The staff provides public education on primary and secondary prevention of hearing and vision problems.

Personnel in **Family Planning** work with local public and voluntary agencies to develop quality family planning services and prenatal, postnatal, and perinatal services which increase the potential for healthy pregnancies and newborns. The activity administers family planning grants to community agencies, sets standards, and provides technical support services to community programs. Special attention is given to adolescents who experience unplanned pregnancies.

Home Health Care Services assist persons who are ill or with disabilities to achieve maximum restoration or maintenance of health, as well as to provide the care needed in cases of terminal illnesses. In 1987, total expenditures by the Community Health Services agencies were $34,739,294. Local agencies reported 288,684 home health care visits by professionals for skilled nursing care in 1987. In addition, a total of 436,681 home health aide visits for disease and disability reasons were reported, serving 10,841 clients. Most people served (74.3 percent) in the home for disease and disability reasons were older than 65 (p. 41).

Maternal and Child Health State Plan: The Maternal and Child Health Plan contains several goals and objectives which relate specifically to people with developmental disabilities:

- By 1995, the proportion of pregnant women beginning prenatal care during the first trimester in all Community Health Service areas will be increased from 70 to 92 percent.
- By 1995, pregnant women in each Community Health Services area will have access to comprehensive prenatal care services that include nutrition, counseling, education, and case management components.

- By 1995, all pregnant women receiving prenatal care administered by or through Community Health Services will have received life style risk assessment and intervention to prevent potentially disabling conditions in their infants.
- By 1995, 80 percent of the Community Health Services will have low cost family planning for females and males of reproductive age.
- Reduce poor birth outcomes among Minnesota infants: lower the total infant mortality rate from 8.9 per thousand to 8.0 per thousand by 1995;
  —lower the black infant mortality rate from 22.7 per thousand to 12.0 per thousand by 1990;
  —lower the Native American infant mortality rate from 14.0 per thousand to 12.0 per thousand by 1990; and
  —maintain or improve the infant mortality rate for whites and East Asian populations through 1990.
- By 1995, the low birth weight rate in every Community Health area will be reduced to 4.5 per 100.
- Assure that all children have quality health care services available.
- Encourage all schools to have a curriculum component on education and intervention in suicide, chemical abuse, mental illness, depression, and child abuse by 1990.
- By 1990, promote the special health concerns of adolescents, assuring that all adolescents be provided with necessary means to enable them to reach their potential in physical, psychosocial, and emotional development.
- By 1990, reduce the number of teenage pregnancies before 18 years of age from 58.0 per thousand to 29.0 per thousand.
- Assure that all children with disabilities receive services to assist them in developing and participating in their lives to the fullest extent possible:
  —By 1990, assure that 100 percent of Minnesota counties will continue to have access to statewide network of specialized health services for children with learning and physical disabilities through Services for Children with Handicaps.
- Assure that all children grow up in a safe, secure, healthful environment:
  —By 1990, assure that 100 percent of Minnesota counties will have injury prevention education including information on car restraints, seat belts, household accidents, and poisonings.
- Assure that all Minnesota mothers and children have appropriate health services available and accessible:
  —By 1990, assure that 100 percent of Minnesota's community health services agencies will have a plan for addressing maternal and child health needs in their service area.

Office of Health Facility Complaints

The Office of Health Facility Complaints was established in 1976 by the Minnesota Legislature with the following responsibilities:

- Receive, investigate, and resolve complaints from any source regarding services provided by health care facilities, health care providers, and administrative agencies;
- Make recommendations to the Commissioner of Health and the Legislature;
- Publish an annual report describing the activities of the office during the preceding year;
- Assist residents of health facilities in the enforcement of their rights; and
- Work with administrative agencies, health facilities, health care providers, and organizations representing consumers on programs designed to provide information about health facilities to residents and the general public.

In addition to investigating complaints of a general nature, the Office of Health Facility Complaints has responsibility for investigating complaints or reports of abuse/neglect of patients or residents in licensed health care facilities, as authorized under the Minnesota Vulnerable Adult Protection Act. A total of 444 complaints/reports of abuse/neglect and failure to comply with the Vulnerable Adults Protection Act were received during 1987.

In addition, 2,134 reports were received from designated reporters in licensed facilities with 54 percent of the reports confirming abuse/neglect or unexplained injury with appropriate action taken. Licensed facilities under the jurisdiction of the Minnesota Department of Health include: nursing homes, hospitals, supervised living facilities, boarding care homes, and state-operated Regional Treatment Centers.

In 1987, the most frequent allegation made under the Vulnerable Adults Protection Act was neglect by health care providers (399 allegations out of a total of 644). The second most frequent allegation was physical abuse (73 allegations). A total of 518 vulnerable adults were included in 444 investigations.In addition to complaints investigated under the Vulnerable Adults Protection Act, there were 448 complaints of a general nature related to facility conditions such as shortage of staff, housekeeping, or dietary problems. Of these complaints, 40.5 percent were substantiated, 45.2 percent were undeterminable, and 14.4 percent were unsubstantiated.

ICF-MR Deficiency Reports

The Developmental Disabilities Act (P.L. 100-146), Section 122 (b)(8), requires that "...the state will provide the State Planning Council with a copy of each annual survey report and plan of corrections for cited deficiencies prepared pursuant to Section 1902(a)(31)(B) of the Social Security Act with respect to Intermediate Care Facility for the Mentally Retarded (ICFs-MR) in such report or plan."

The Minnesota Governor's Planning Council on Developmental Disabilities routinely receives copies of ICF-MR Deficiency Reports from the Minnesota Department of Health. Each report is reviewed, and deficiencies concerning physical plant and personnel are tallied. Items pertaining to active treatment, program plans, assessments, exams, and residents are summarized.

From October 1, 1987, to April 30, 1989, the number of reports per facility size was as follows:

Number of Reports Reviewed	Facility Size
1,558	16 and fewer beds
218	17 to 299 beds
22	300 or more beds

Among the reports reviewed, there were approximately 310 facilities with 16 or fewer beds; 47 facilities with 17 to 299 beds; and 2 with 300 or more beds.

Minnesota Department of Human Services

The Department of Human Services (DHS) is responsible for planning, administering, and coordinating the state's social services and public assistance programs. Since Minnesota has a state-supervised, county-administered system of providing human services, few services are actually delivered by the state agency. The various divisions of DHS are responsible for setting statute-based rules and policies that provide needed services to a diverse population. Most of the programs are operated by each of Minnesota's 87 counties.

The Department of Human Services is the largest of Minnesota's state agencies. As of the 1987-1989 biennium, DHS administered a $4 billion budget, the largest budget of any state agency. The majority of that money is dedicated to programs such as Medical Assistance and Aid to Families with Dependent Children. Support for such programs comes from various combinations of local, state, and federal sources.

DHS is divided into six major program areas: (1) Family Support Programs, (2) Finance and Management, (3) Health Care and Residential Programs, (4) Legal and Inter-Governmental Programs, (5) Mental Health Programs, and (6) Social Services Programs. In addition, the Minnesota Council on Children, Youth and Families is administered by the Department.

The following programs represent only a few of the array of services available to persons with developmental disabilities and their families through the Minnesota Department of Human Services.

Family Support Programs

This Program Area includes an Office for Civil Rights, Child Support Enforcement; Refugee and Immigrant Assistance, Reports and Statistics, and Assistance Payments. Only the latter Division is described below.

Assistance Payments Division: This division provides income maintenance through cash assistance, food stamps, and payments to providers of medical and health care services, to and on behalf of needy citizens of the state. Cash assistance and medical payments help provide a basic standard of living and enable low income citizens to have access to quality medical care.

The number of people requiring assistance and the cost of programs adjust in relation to demographic shifts, as well as changes in national, state, and local economic conditions.

Local agency staff, operating under Division guidelines, determine individual eligibility for all programs, make cash assistance payments, and issue food stamps. Division guidelines provided to local agencies are designed to maximize the use of federal funding while ensuring that needs of low income persons are met.

The Assistance Payments Division also carries out management control functions for Aid to Families with Dependent Children (AFDC), food stamps, and medical assistance. The Division reviews local agency management of the food stamp program and gathers necessary data to claim federal funds and complete a wide range of internal management reports. In addition, postpayment audits are conducted to detect abuse and/or fraud by recipients or providers of the medical assistance program and recipients of cash assistance and food stamp programs.

The Division works to develop state plans, coordinates the delivery of services among state and local agencies, develops service standards for each disability, provides technical assistance to counties and service providers, administers certain categorical and federal block grant programs, monitors county and provider compliance with standards, promotes prevention services, and evaluates the effectiveness of services.

Health Care and Residential Programs

This Program Area administers the following services: Health Care Management, including Medical Assistance (Medicaid) and General Assistance Medical Care; Health Care Support; Long-Term Care Management; Audits, Provider Appeals; Systems Administration and Coordination; Residential Program Management; Regional Treatment Centers; and Nursing Homes. Two relatively new features of the Medical Assistance Program of the Health Care Mangement Division are highlighted below:

Children's Home Care Option: The Children's Home Care Option provides Medical Assistance eligibility to children with disabilities who live with their families. This program is also known as the TEFRA Option or Program. "TEFRA" is the acronym for Tax Equity and Fiscal Reform Act of 1982. Utilization of this federal option under Medicaid was created by the 1988 Legislature and became effective July 1, 1988. It is currently being used by over 400 families in Minnesota. The program is viewed as a successful family support program.

To be eligible for the Children's Home Care Option, a child must meet the following criteria: (a) the child must be certified as having a disability; (b) if the child was in a medical institution, he or she would be eligible for Medical Assistance; (c) the child must require a level of care provided in a hospital, skilled nursing facility (SNF), or Intermediate Care Facility (ICF), or Intermediate Care Facility for Persons with Mental Retardation (ICF-MR); (d) it is appropriate to provide the care to the child at home; and (e) the estimated cost to Medical Assistance to provide the care at home will not be more than the estimated cost to Medical Assistance to provide the care within the institution.

If a child meets the above criteria, the child's Medical Assistance eligibility is determined based only on the income and assets of the child. The Children's Home Care Option offers children and their families all of the services available under the regular Medicaid program. Such services include: (a) home health services (medically necessary services such as nurse visits, private duty nursing, personal care services, therapy services, and medical supplies and equipment); (b) prescribed drugs; (c) medical transportation; and (d) insurance premium reimbursement.

Community Alternative Care (CAC) Program: On May 13, 1985, the Department of Human Services received approval from the Health Care Financing Administration for a Home and Community-Based Model Waiver for Chronically Ill Individuals. Because it is a model waiver, no more than 50 individuals can be eligible for waivered services at any one time unless another waiver is applied for and received. The program is for individuals with chronic illness or disability who are currently living in hospitals or who are at risk of placement in an acute care facility.

The Community Alternative Care Program provides Medical Assistance eligibility for individuals while they are living in the community. Eligibility is based solely on the individual's income and assets, even though the individual may be living at home with parent(s) or spouse. The CAC Program provides services that customarily cannot be paid for under Medical Assistance, and removes restrictions on some services usually covered by Medical Assistance. Waivered services are used to supplement, not replace, other funding sources such as Medicare or Community Service funds.

Legal and Inter-Governmental Programs

Division of Licensing: Licensing, mandated by the Minnesota legislature, is a state service that regulates residential living programs, nonresidential programs, and agency services to children and specified groups of adults with functional impairments or handicaps. The definition of "persons with handicaps" includes persons with mental retardation, mental illness, chemical dependency, or physical handicaps. "Children" are defined as persons who have not reached their eighteenth birthday.

The purpose of public licensure is to protect children and specified adults being served in residential and day programs. Licensing is regulation in the public interest with both positive and negative sanctions. A license gives positive sanctions of authority to operate a service in the view of the public. Forfeiture orders, probation, denial, revocation, or suspension of a license imposes negative sanctions, limiting or prohibiting operation at the risk of further legal sanctions.

Licensing is administered by the Department of Human Services through regular inspection and evaluation to: determine minimal compliance; investigate complaints; provide information and assistance to individuals and groups requesting licenses; and to make licensing compatible with the changing needs of clients by revising licensing laws, regulations, policies, and procedures.

Licensing evaluations may occur throughout the year, but are mandatory at least biannually. A typical licensing review includes the following standard activities: entrance interview, tour and inspection of the entire facility, review of staff and client records, review of administrative policies and procedures, direct observation of programming and meal service, and an optional exit interview with the program director and/or administrator. In addition to regular licensing visits, the licensor may also make unannounced or announced visits to investigate complaints or to review compliance with licensing orders.

The programs for persons with developmental disabilities that are licensed directly by the DHS Licensing Division include:

- **Aversive and Deprivation Procedures for Persons with Mental Retardation or Related Conditions:** Applied to programs licensed under the Human Services Licensing Act that provide services to children and adults with mental retardation or related conditions, mental illness, chemical dependency, or physical disability—Minnesota Rules, parts 9525.2700 through 9525.2800.
- **Community Residential Facilities for Persons with Mental Retardation and Related Conditions:** Licensed under Minnesota Rules, parts 9525.0210 through 9525.0430;
- **Day Training and Habilitation Services for Persons with Mental Retardation and Related Conditions:** Licensed under Minnesota Rule, "Licensure of Training and Habilitation Services for Adults with Mental Retardation or Related Conditions," Minnesota Rules, parts 9525.1500 through 9525.1690.
- **Regional Treatment Centers:** Licensed under Minnesota Rules, parts 9525.0210 through 9525.0430;
- **Residential-Based Habilitation Services (Waivered Services):** Supported living services for children and adults, in-home family support services (including foster care), and for living arrangements for four or fewer people—Minnesota Rules, parts 9525.2000 through 9525.2140.

- **Residential Facilities and Services for Persons with Physical Handicaps:**—Minnesota Rules, parts 9570.2000 to 9570.4300.
- **Semi-Independent Living Services:** Licensed under Minnesota Rules, parts 9525.0500 through 9525.0660; and
- **Reporting Maltreatment of Vulnerable Adults in Licensed Facilities:**—Minnesota Rules, parts 9555.8000 through 9555.8500.

Mental Health Programs

Mental Health Division: The Mental Health Division is responsible for administering laws relating to mental health, evaluating the needs of people with mental illness in terms of state and federally funded services, and adopting rules for minimum standards in community mental health services. The Division reviews and approves county mental health plans. Staff make recommendations regarding mental health services to county boards and program administrators, and provide technical services to communities and advocacy groups in determining local needs and planning community health programs.

The Division maintains a data collection system to provide information on: (a) the prevalence of mental illness,(b) the need for specific mental health services and other services needed by people with mental illness, (c) funding sources for those services, and (d) the extent to which state and local areas are meeting the needs for services.

In September 1987, the Mental Health Division contracted with the University of Minnesota to study the incidence of mental illness in Minnesota. Study results indicate that there are between 22,000 and 29,000 people in Minnesota who have serious and persistent mental illness. In addition, the study estimated that between 63,000 and 154,000 persons, ages 17 and under, have a "childhood maladjustment," a concept used to describe a broad range of clinical phenomena. (Minnesota Department of Human Services, January 1989, p. 16)

Minnesota Comprehensive Mental Health Act: Passed in 1987, the Minnesota Comprehensive Mental Health Act required counties to establish an array of services for persons with mental health problems at phased-in dates over a four-year period.These services include education and prevention, emergency, outpatient, community support programs, day treatment, residential, acute care hospital, case management, and screening for admission to inpatient/residential treatment.

In 1989, the Minnesota legislature amended the Act to clarify requirements for availability of services to adults. At the same time a separate bill was passed, requiring provision of mental health services for children in all counties by January 1, 1992. Mandated children's mental health services include services similar to those required for adults, plus early identification and intervention, family community support, therapeutic foster care, and home-based family treatment. Pilot projects were funded for therapeutic foster care and home-based services in the second year of the biennium. Central to the Comprehensive Children's Mental Health Act is coordination of service planning, development, funding and implementation on the state, local, and individual levels.

Funding was also made available to implement mandates under the federal Nursing Home Reform Act (P.L. 100-203) which prohibits nursing facilities from admitting any new resident with mental illness after January 1, 1989, unless the state mental health authority has determined that the individual's physical and mental condition requires the level of services provided by the nursing facility, and whether the individual requires treatment for mental illness. State funding will be used to provide alternative placements for individuals inappropriately residing in nursing homes.

Three-Year Plan for Services for Persons with Mental Illness: Among the provisions of the State Comprehensive Mental Health Services Planning Act (P.L. 99-660), each state is required to prepare a three-year plan, updated annually, for the establishment of comprehensive community-based services for persons with mental illness. The plan was submitted to the National Institute of Mental Health (NIMH) in January 1989 by the Mental Health Division of the Minnesota Department of Human Services. Some highlights from the 1989 plan include:

- Add central administrative staff to: (1) provide oversight and technical assistance to counties and providers of services, (2) implement an information system, (3) address mental health needs of the growing elderly population, and (4) provide expertise in the area of housing issues for persons with mental illness.
- Provide a full array of Community Support Program (CSP) services in all 87 counties by January 1, 1990, and reduce caseloads in counties with existing CSPs.
- Implement a cooperative public education/antistigma effort in cooperation with the Minnesota Department of Health.
- Via an interagency agreement with the Division of Rehabilitation Services: (1) increase vocational training programs for persons with a mental illness, and (2) enhance the employability and improve the work records of persons with mental illness.
- Implement mandates under the Federal Nursing Home Reform Act (P.L. 100-203) as described above.
- Develop a comprehensive, balanced system that addresses the needs of all children in every community across the state. Services will include early identification and intervention, and will focus new resources on youths with severe emotional disturbance.
- Create a mental health system that functions as a coordinated set of services for children across all agencies.
- Establish a system of services that is child-/family-based.

The 1989 legislature supported the creation of a children's mental health unit within the Mental Health Division. This unit will oversee the development of the system and will implement the 1989 Comprehensive Children's Mental Health Act, as well as provide expertise on meeting the needs of children with emotional disturbance. In addition, the Commissioner of Human Services will launch an extensive interagency effort in Minnesota on behalf of the mental health needs of all children, and an information management system will be established to provide clear usable information for decision making.

Funding of Mental Health Services in Minnesota: Table 8 provides estimated funds needed in calendar year 1989 to provide an array of mental health services. Revenues are derived from a number of sources, including:

- Minnesota Community Social Services Act,
- Medical Assistance,
- General Assistance, Medical Care,
- Minnesota Rule Numbers: 5, 12, 14, and 36,
- Regional Treatment Center state appropriation and county match,
- Federal Mental Health Block Grant/State Special Projects, and
- Title XX and Title IV-E.

Minnesota contributes approximately 51 percent toward the total mental health budget. The counties contribute over 23 percent and the federal government over 22 percent.

Table 8
Estimated Funding for Mental Health Services
Calendar Year 1989

MENTAL HEALTH SERVICE	FUNDING SOURCE				
	County	State	Federal	Other	Total
Education and prevention	$ 542,228	$ 124,481	$ 107,742	$ 0	$ 774,450
Emergency services	1,761,669	404,432	350,047	0	2,516,148
Outpatient services	14,582,088	12,585,348	11,958,815	0	39,396,251
Case management	1,754,305	3,177,731	2,873,964	0	7,806,000
Community support services (including day treatment)	4,548,800	8,563,679	1,939,963	0	15,052,441
Residential treatment	16,657,660	22,623,010	8,441,011	800,000	48,521,681
Acute care hospital	4,518,319	21,093,752	16,414,110	0	42,026,181
Regional treatment center	9,210,726	54,654,126	10,566,997	5,885,883	80,317,732
Prepetition and other screening	4,148,631	952,413	824,341	0	5,925,385
Special projects	160,000	1,520,000	1,767,000	0	3,447,000
Other mental health Services	881,823	202,443	175,220	0	1,259,485
State administration	0	600,000	390,000	0	990,000
TOTAL DHS FUNDING	$59,036,248	$126,501,413	$55,809,210	$6,685,883	$248,032,755
Percent of total	23.8%	51.0%	22.5%	2.7%	100.0%

Source: Minnesota Department of Human Services. (1989, January).

In addition to those costs listed in Table 8, mental health services are also funded by the departments of Education, Corrections, and Jobs and Training. Additional revenues come from direct federal funding to providers through Medicare and Veterans Administration, plus private insurance and private pay.

The largest dollar increase since 1987 has been for inpatient services at the Regional Treatment Centers (RTC)—an increase of $17 million. A major reason for the current increase in RTC costs is a 1987 audit conducted by the Health Care Financing Administration, which required the state to hire 175 more staff to meet federal standards.

As required by the Comprehensive Mental Health Act, the Mental Health Division has closely supervised the counties in the implementation of the Mental Health Act. County plans for 1989 budgeted a total of $73 million in local (Community Social Services Act) funds for mental health, compared to $57 million in 1987.

Social Services Programs

Minnesota Board on Aging (MBA): The Minnesota Board on Aging is committed to serving the state's 700,000 older adults by assisting them in living independent, meaningful, dignified lives in their own homes or places of residence with emphasis on the reduction of isolation and the prevention of untimely or unnecessary institutionalization.

The Board consists of 25 members who are appointed by the Governor. Staff is provided by the Department of Human Services. Roles and responsibilities of the Board include: (a) advising the Governor, state departments, and others about the status and needs of older Minnesotans; (b) administering the Older Americans Act, as amended; (c) acting as an advocate for the rights and dignity of older Minnesotans; and (d) promoting the talents and contributions of older Minnesotans.

The Board administers over $18 million of federal and state funds annually. These funds generated more than $10 million in other resources. In addition, program participants contribute nearly $7 million. The primary thrust of Minnesota's network of services to persons who are elderly comes from the federal Older Americans Act. This law connects the state to a national framework; it provides the largest single source of financing; and it initiates the network's overarching mandate to promote the dignity and independence of all older people.

Each year, over 200,000 older Minnesotans benefit from one or more of the programs and services provided by the aging network. Major categories of activities include:

- **Area Planning:** 14 Area Agencies on Aging (AAAs) plan for and administer programs and services for older people. The AAAs develop an Area Plan which is approved and funded by the MBA. The MBA monitors the activities of the AAAs and provides technical assistance and consultation.
- **Social Services:** These services include transportation, health screening, legal services, adult day care, home health aide, housing assistance, recreation, counseling, advocacy, homemaker services, chore services, and senior centers. The greatest expenditures in 1988 for these services included: legal services ($1,118,125); transportation ($1,405,550); services coordination ($688,160); chore services ($824,634); and home health aide ($790,607).
- **Nutrition:** The Nutrition Program provides over 4.5 million meals a year. There are 433 congregate dining sites that provide 14,800 meals each service day. Home delivered meals are available to those who are unable to leave their homes. Nutrition sites often serve as access points to the social service system.
- **Office of Ombudsman for Older Minnesotans:** Two areas are addressed by this office. The Long Term Care Ombudsman, located in seven regional offices, investigates complaints of nursing home and boarding care residents and their families, and assists them in achieving settlements. The Acute Care Ombudsman assists Medicare hospital patients and their families in hospital admissions, preventing premature discharge, and in gaining access to services following hospitalization.
- **Legal Services:** Through Older Americans Act funds, 20 legal service offices provide legal advice, representation, and education to older persons throughout Minnesota. Aimed at serving those with the greatest social or economic need, most cases involve health care, income programs, housing utilities, and consumer problems.
- **Senior Centers:** Senior Centers often serve as the point of entry to the vast network of aging-related services and resources. Matching grants are available through AAAs for staffing, remodeling, weatherization, accessibility, and other needs.

- **Volunteer Programs:** The Board administers state funds for the Senior Companion Program, the Foster Grandparent Program, and the Retired Senior Volunteer Program.

Minnesota Board on Aging State Plan (FY 1987-1990): Goals and objectives are as follows:

- Assure access to a continuum of services supporting wellness, independent living, long-term, and acute care:
  - —Promote the Area Agency on Aging as the primary mechanism for coordination within its Planning and Service Area;
  - —Develop strategies at state and local levels (both public and private) that will promote effective coordination of long-term care policy development, planning, and service delivery to older persons statewide;
  - —Develop and expand volunteer opportunities for older people;
  - —Promote health and wellness, in cooperation with the Minnesota Department of Health and the area agencies on aging.

- Establish a strong leadership role as an advocate for the dignity, rights, and status of older people:
  - —Maintain and strengthen the statewide Long Term Care Ombudsman program;
  - —Develop and implement a biennial legislative program, in cooperation with AAAs and others, that has a positive impact on the rights and benefits of older Minnesotans and on the development and delivery of programs promoting independent living;
  - —Advocate for program development that fills gaps in protective services for older persons while safeguarding their individual rights to the fullest extent possible;
  - —Promote increased involvement from the private sector in meeting the legal needs of older persons;
  - —Develop a process that assures the opportunity for full participation of minority persons who are elderly and persons with disabilities in programs and services where special access problems occur.

- Enhance the MBA's identity as a strong, independent, unified voice of older people:
  - —Introduce a program of public information and education about the Minnesota Board on Aging and its programs and activities;
  - —Establish a comprehensive, coordinated statewide program to encourage intergenerational relationships;
  - —Develop public/private partnerships with the corporate community to enhance the available opportunities and the life satisfaction of older persons.

Children's Services Program

Foster Care Program: As of December 31, 1986, there were 5,616 children living in licensed foster care homes. This number included 1,824 children with mental, physical, and emotional disabilities. Of that number, there were 735 children with mental retardation. Among those with mental retardation, 288 children had additional disabilities:

Additional Disability	Number of Children
Emotional disturbance/mental illness	48
Hearing, sight or speech impairment	86
Physical disability	122
Other clinical diagnosis	32

As of 1988, there were 1,955 adults with mental retardation and related conditions in adult foster homes.

Foster parents receive a basic maintenance rate to cover room, board, clothing, and recreation. They are also eligible for additional maintenance payments based on an evaluation of the child's special needs through a "Difficulty of Care" assessment by the county social services agency. The child foster care program is funded by county child welfare funds and parental fees. It is partially reimbursed by the Title IV-E Program of the Social Security Act.

Subsidized Adoption Program: As of July 1, 1987, there were 808 children with special needs and 602 families served by subsidized adoption in Minnesota. This program increased by 23 percent over the previous year, serving an additional 134 children.

An adoption subsidy is made available for a child with special needs to provide financial reimbursement for expenses incurred related to the child's special needs. A child with special needs who is eligible for an adoption subsidy is under the guardianship of the Commissioner of Human Services as a "state ward," or is under the guardianship of a Minnesota licensed child placing agency. The agency responsible for placing the child determines whether an adoption subsidy is needed to ensure the child an adoptive home. All children who receive an adoption subsidy are eligible for the benefits of Medicaid (Medical Assistance).

The average monthly maintenance payment under this program in Fiscal Year 1987 was $330. Total expenditures in Fiscal Year 1987 amounted to $1,761,533 for maintenance, medical, and special costs. In addition, $547,448 were expended under the Medicaid Program.

Community Social Services Division

This Division is responsible for planning, developing, and implementing public social services throughout the state as required by state law and Title IV and XX of the Social Security Act. Services are specifically designed to help individuals achieve or maintain self-support and economic independence and to secure protection from neglect, abuse, or exploitation for those unable to protect their own interests. Social services are offered by county social services agencies.

Public Guardianship Office: The Public Guardianship Office oversees approximately 6,100 wards of the Commissioner of Human Services. The purpose of this Office is to ensure that appropriate decisions are made on behalf of individuals who are unable to make decisions independently. Eligible individuals must be 18 years of age or older with a diagnosis of mental retardation. Public guardianship/conservatorship is viewed as the most restrictive form of substitute decision making for an individual, and is sought only in the absence of an appropriate private guardian/conservator.

The Public Guardianship Office has the following major areas of responsibility:

- Carefully admit new guardianships, ensuring that the least restrictive alternative is sought whenever possible.
- Develop and clarify policies and procedures related to serving the best interests of the wards.
- Provide leadership for decision making with respect to controversial and/or ethical considerations.
- Remove inappropriate public guardianships, including outdated guardianships for persons with epilepsy. (Historically, to receive services, individuals with mental retardation and/or epilepsy were required to be a ward of the Commissioner of Human Services. While this is no longer true, some inappropriate guardianships remain.)

- Provide training and technical assistance. Currently, the Public Guardianship Office handles over 200 calls per month, primarily with county social service agencies in need of technical assistance. The majority of the powers of the public guardian/conservator have been delegated to the county social service agency.

Deaf Services Division

The Deaf Services Division is required by statute to ensure that persons with hearing impairments have access to a full array of human services available in Minnesota.

The Division manages eight Regional Service Centers located in Crookston, Duluth, Fergus Falls, Mankato, Rochester, St. Cloud, St. Paul, and Willmar. These Centers serve as an entry point for people with hearing impairments for accessing human service agencies. Regional staff provide information, referral, advocacy, technical assistance, and training to individuals with hearing impairments and to public and private human service agencies. In addition, regional staff distribute adaptive telephone equipment to individuals in need.

The Developmental Services Section of the Deaf Services Division is responsible for statewide planning and program development to meet the human service needs of people with hearing impairments. The Division also administers contracts for statewide interpreter referral, specialized mental health services, and services to people who are both deaf and blind.

For Fiscal Year 1989, the following service goals will be met:

- Approximately 1,200 people with hearing impairments will be served;
- Approximately 110 Access Policies or Procedures will be adopted by human service agencies;
- Approximately 250 training events will be provided to human service agencies; and
- Over 1,500 Telecommunication Devices will be distributed.

Division for Persons with Developmental Disabilities

This Division plans, develops, coordinates, and monitors community services for persons with mental retardation and related conditions. "Related condition" is defined as:

> *a person with a severe, chronic disability that is: (a) attributable to cerebral palsy, epilepsy, autism, or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation or requires treatment or services similar to those required for persons with mental retardation; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, or capacity for independent living. (MINN. STAT. Chapter 252.27, Subd. 1)*

The Division supervises county social services and human services agencies that administer programs for persons with mental retardation and related conditions under the Community Social Service Act and administers the federal home and community-based services waiver under the Title XIX Medical Assistance program.

Table 9

Services to Persons with Mental Retardation and Related Conditions in Minnesota:

Number of Persons Served and Characteristics by Type of Service, 1985 through 1988

	NUMBER OF PERSONS SERVED BY SERVICE TYPE				PERCENTAGE OF PERSONS SERVED IN SERVICE CATEGORIES BY AGE GROUP, GENDER, AND LEVEL OF FUNCTIONING								
	Number of Persons Served				Age Group		Gender		Level of Functioning				
SERVICE TYPE	SFY1985	SFY1986	SFY1987	SFY1988	Birth to 20	21 and Over	Male	Female	Pro-found	Severe	Moder-ate	Mild	Other
Regional Treatment Centers	1,997	1,788	1,626	1,498	2%	98%	59%	41%	64%	19%	7%	9%	1%
ICFs-MR (Community)	4,945	4,988	4,961	4,748	8%	92%	53%	47%	23%	29%	22%	21%	5%
Day Training and Habilitation/Developmental Achievement Centers	4,880	6,364	6,094	6,267	17%	83%	52%	48%	17%	32%	23%	25%	3%
Semi-Independent Living[a]	884	757	888	1,075	4%	96%	—	—	0%	2%	21%	74%	3%
Waivered Services[a]	278	614	991	1,565	29%	71%	59%	41%	—	—	—	—	—
Family Subsidy[a]	203	240	245	410	100%	0%	—	—	—	—	—	4%	8%

Source: Minnesota Department of Human Services. (1989, June).

Note: Developmental Achievement Center statistics pertaining to sex and level of functioning refer to adults only; statistics pertaining to persons served are based on the calendar year rather than state fiscal year.

[a]Blank spaces indicate that data are not available.

The Division also prepares and proposes state policies, legislation, and rules; and it administers them as adopted and legislated. Administration includes county planning, case management, and assessing the need for public and private residential and day services by persons with mental retardation and related conditions.

Community residential, day, support services, and regional treatment centers are funded by various combinations of federal, state, local, county, and parental resources. The Division provides technical assistance to county agencies and service providers; and it plans and develops alternatives to residential and institutional care. The Division's intent is to provide services in the least restrictive and most normal setting possible so that individual service plans may be properly carried out for each client.

The Division strives to establish service options, and foster societal conditions and public attitudes that promote a safe and healthy life in the community, culturally and age-appropriate lifestyles, meaningful interpersonal relationships, and maximum appropriate independence, self-determination, and expression of individuality.

Tables 9, 10, and 11 describe the number of persons served and their characteristics, expenditures for services, and average cost per person by service category:

Family Subsidy Program: This Program provides a monthly stipend of up to $250 to families with a child with mental retardation or a related condition. The stipend enables the child to remain at home and delay or avoid placement in a community ICF-MR or Regional Treatment Center. Applications are taken by county social service agencies with approval and funding completed by the Department of Human Services. Stipends may be used to purchase special equipment, food, or

clothing needed by the child as well as respite care, baby-sitting, or transportation. Results of a survey of parents who use the program, reported in *Welsch vs. Levine* Policy Analysis Series Paper No. 18, revealed that parents find the program extremely beneficial. As of June 1989, there were 375 families receiving family subsidies; and there were another 140 families on the waiting list for this service.

Semi-Independent Living Services (SILS): This program serves persons who do not need 24-hour supervision. It provides training in skills needed by a person with mental retardation or a related condition to live independently—skills such as household management, personal grooming and hygiene, and use of public services. As of June 1989, there have been 1,145 persons served; and there is a waiting list of 400 persons for this program.

Table 10

Services to Persons with Mental Retardation and Related Conditions in Minnesota: Expenditures by Service Category

[State Fiscal Year (SFY) 1988 and Calendar Year (CY) 1986]

SERVICE CATEGORY	MEDICAL ASSISTANCE (SFY1988)[a]	COMMUNITY SOCIAL SERVICES (CY1986)[b]	ADDITIONAL STATE APPROPRIATION (SFY1988)
Regional Treatment Centers	$106,258,543	$ 294,786	—
Intermediate Care Facilities for People with Mental Retardation	$110,854,046	2,627,082	—
Developmental Achievement Centers	21,200,483	20,327,937	—
Semi-Independent Living	—	4,330,469	$4,365,751
Waivered Services[a]	24,371,383	NA	NA
In-Home Family Support	—	1,083,913	1,062,700
Other Community Services	—	$28,465,350	—
TOTAL	$262,684,455	$57,129,537	$5,428,451

Source: Minnesota Department of Human Services. (1989, June).

[a]Includes Federal Funding Participation (FFP), plus state and local match.

[b]Current data are not available. Amounts include payments for screening as well as services.

Table 11

Services to Persons with Mental Retardation and Related Conditions in Minnesota: Average Cost Per Person by Service Category

(State Fiscal Year 1988)

SERVICE CATEGORY	AVERAGE COST PER PERSON PER DAY	AVERAGE ANNUAL COST PER PERSON[a]
Regional Treatment Centers	$194.00	$61,994
ICFs-MR (Community)	$ 74.66	$23,348
Developmental Achievement Centers[b]	$ 32.25	$ 7,096
Semi-Independent Living	$ 11.22	$ 4,061
Waivered Services[c]	$ 50.91	$15,573
Family Subsidy	$ 7.10	$ 2,592

Source: Minnesota Department of Human Services.

[a]Computed: Total Annual Expenditure for Service Category/Number of Persons Served.

[b]The annual cost of Developmental Achievement Centers is based upon 220 days of services. Over a 365-day period, the average cost would be $19.44 per day.

[c]Includes payments for cost of screenings as well as services.

Alternative Disposition Plan for Persons with Developmental Disabilities Living in Minnesota Nursing Facilities: This plan was submitted by the Minnesota Department of Human Services as required under Public Law 100-203, Omnibus Budget Reconciliation Act (OBRA). This federal law required all states to assess the service needs of persons with mental retardation or related conditions who currently reside in nursing facilities, to determine the appropriateness of their current services and to prevent future inappropriate nursing home placements of such persons. By April 1, 1990, all nursing home residents with mental retardation or related conditions must be assessed and provided with appropriate services and/or placements. A preadmission screening program must also be in place by January 1, 1989.

In 1987, there were an estimated 1,200 individuals with mental retardation or related conditions living in nursing homes with their care funded by Medicaid. Since that time, considerable progress has been made. Approximately 500 individuals have been assessed; 164 have been relocated to other services (at an estimated cost of $4.8 million annually); and an additional 110 people will be placed. An additional 150 individuals were found to be incorrectly diagnosed as having mental retardation or a related condition; and 240 persons in the original target group are deceased. Under the current plan, there are an estimated 275 persons who need to be relocated.

The 1990-91 State Plan for Services to Minnesotans with Developmental Disabilities: This plan addresses the areas of case management, support for families and consumers, homes for persons with developmental disabilities, jobs and job training, training and support for service providers, and provisions for quality assurance.

Minnesota Council on Children, Youth, and Families

The Council is a 23-member advisory body that provides public advocacy and support on selected issues relating to children, youth, and families. The goals of the Council are to:(1) improve interagency coordination on issues relating to children, youth, and families; (2) develop better statewide policies on issues targeted for action by the administration; (3) provide forums where families can voice concerns; and (4) serve as an information resource on the needs of children, youth, and families.

In its *1988 Annual Report to Governor Perpich* (1988, October), the Council documented the increase in poverty among children in the state. The Council set forth the following goal: "Families need to be economically self-sufficient to provide for the basic needs of their children." The objective stated in support of this goal was: To minimize the impact of poverty upon children, especially children in their earliest years, by making needed health, education, and social services universally available to children from low-income families. The Council will implement several stategies including:

- Increase funding for programs so that no eligible child is denied access to a program because of lack of funding;
- Improve participation rates for programs that promote the well-being of children;
- Expand, where possible, program eligibility limits to at least 185 percent of the federal poverty level to include children from working poor families;
- Identify gaps in the delivery of services and propose new ways to ensure better access to programs;
- Ensure the quality of children's services so that programs further the development of children.

Subsequently, Council reports have documented the participation rates and funding patterns over the last decade for five major programs for children: Early Childhood Health and Development Screening (ECS); Early Periodic Screening, Diagnosis and Treatment (EPSDT); Child Care Subsidy Fund; Early Childhood Family Education; and Head Start.

In addition, the Council on Children, Youth, and Families established a Blue Ribbon Task Force to study the early childhood development service system in Minnesota. The goal of the Task Force was to describe what a comprehensive system of services might look like as well as to identify accessibility to services and quality issues.

Department of Jobs and Training

The purpose of the Department of Jobs and Training is to develop, implement, and coordinate employment and income policies for the state of Minnesota. It is the state's principal agency for employment and job training, vocational rehabilitation, and the unemployment insurance program.

Division of Rehabilitation Services (DRS)

The purpose of the Division of Rehabilitation Services (DRS) is to enable individuals with disabilities to significantly increase their vocational, personal, and financial independence, with special attention to those with more severe disabilities. To accomplish this mission, DRS provides an array of services that includes training and job placement.

Vocational Rehabilitation focuses on achieving employment outcomes. Each person is assigned to work with a counselor and receives counseling and guidance based on a jointly developed individual written rehabilitation plan. The Division has cooperative arrangements with public schools, state Regional Treatment Centers, and state correctional institutions to help provide broader and more timely vocational rehabilitation services. Employment opportunities include both competitive employment and supported employment.

In Fiscal Year 1988, 3,760 individuals were placed in employment. Of that number, 582 were placed in supported employment or sheltered employment; and 36 were rehabilitated as homemakers.

The **Independent Living Program** supports opportunities for individuals with severe disabilities to live independently and function within their family and community. The primary service delivery mechanism is a network of Independent Living Centers located throughout the state. These Centers are supported with both state and federal funds. In 1989, the Legislature authorized additional supports for the establishment of satellite programs in the existing six Centers for Independent Living and the establishment of one additional Center in an area of the state currently having no access to independent living services.

In Fiscal Year 1988, 2,428 persons were served by Centers for Independent Living.

Division of Rehabilitation Services State Plan: This plan describes the services available to individuals including:

- Evaluation of rehabilitation potential;
- Counseling guidance and referral;
- Physical and mental restoration services;
- Vocational and other training services;
- Services to members of families necessary to the adjustment of the individual with a disability;
- Interpreter services for people who are deaf;
- Telecommunications, sensory, and other technical aids and devices;
- Recruitment and training services to provide new employment opportunities;
- Listing of suitable employment;
- Employment services needed to obtain appropriate employment; and
- Occupational licenses, tools, equipment, stocks, and supplies necessary to begin a particular occupation as well as other goods and services to enhance an individual person's employability.

In addition, the DRS State Plan includes a description of the agency's efforts to expand and improve services to individuals with severe disabilities, a description of the quality, scope, and extent of supported employment services, information concerning the development of rehabilitation technology services, and a description of the approach used in carrying out ongoing needs assessments.

Supported Employment Grant from OSERS: In October 1985, the state of Minnesota received a grant from the United States Department of Education, Office of Special Education and Rehabilitative Services (OSERS). The Division of Rehabilitation Services of the Department of Jobs and Training is the host agency for this grant. The purpose of the OSERS grant is to increase the quantity and quality of paid integrated work opportunities for persons with severe disabilities and to improve their quality of life as measured by integration and productivity.

State Services for the Blind and Visually Handicapped (SSB)

The mission of SSB is to facilitate the achievement of vocational personal independence by children and adults who are blind or who have a visual disability. In 1988, 14,437 persons who are blind or who have visual disabilities were served. More than 425 volunteers helped to make the services possible. Total revenue in 1988 was $9,620,534, which was derived from federal ($5,488,362), state ($3,452,000) and other sources ($680,172).

State Job Training Office

In Minnesota, the Job Training Partnership Act (JTPA) is administered by the State Job Training Office, a division within the Department of Jobs and Training. This office provides staff support to the Governor's Job Training Council, which is responsible for making recommendations to the Governor on policies, coordination of services, and the implementation of a state plan.

The purpose of the Job Training Partnership Act is to establish programs to prepare youth and unskilled adults for entry into the labor force. Job training is provided to individuals who are economically disadvantaged and others who face serious barriers to employment.

There are 17 Service Delivery Areas in Minnesota which plan and provide services according to locally defined needs and priorities. Within each of these local areas is a Private Industry Council. It is the role of these Councils, together with the local elected officials, to determine: what services will be provided, what agency or agencies will manage and operate the program, and what populations will be targeted for services.

Between July 1, 1988, and April 30, 1989 (nine months), 15,158 people in Minnesota were served through the JTPA Title II-A Program. Of that number, 1,940 people (12.8 percent) had disabilities.

Project Head Start

Minnesota Project Head Start is administered by the Economic Opportunity Office of the Department of Jobs and Training. Head Start is a demonstration program authorized under the Economic Opportunity Act of 1964 (P.L. 95-568) to provide comprehensive developmental services for low income preschool children. Since its inception in 1965, Head Start has provided educational, social, medical, dental, nutrition, and mental health services to over 10 million children and their families across the United States. Head Start is a family-centered child development program with the central goal of increasing social competence in children of low-income families. Social competence refers to a child's everyday effectiveness in dealing with both present environment and later responsibilities in school and life.

In Minnesota, Head Start services are delivered locally by community action agencies, Indian reservation governments, private nonprofit agencies, and one school district. In Fiscal Year 1988, there were 6,632 preschool children enrolled in Head Start. Nearly 900 of this number were children with disabilities (mental retardation, health impairments, visual disabilities, hearing impairments, emotional disturbance, speech and language impairments, orthopedic disabilities, and learning disabilities), or 13.3 percent of the total number served. The total budget for Fiscal Year 1988 was $14,599,874, of which $1,915,945 were state funds. The average cost per child in 1988 was $2,345.

Minnesota Disability Law Center

Legal Advocacy for Persons with Developmental Disabilities

The Developmental Disabilities Act (P.L. 100-146) required that each state have a system to protect and advocate for the rights of persons with developmental disabilities. Congress appropriated funds to support this system.

Legal Advocacy for Persons with Developmental Disabilities is a part of the Minnesota Disability Law Center of the Legal Aid Society of Minneapolis. This agency has been designated by Governor Perpich as the Minnesota Protection and Advocacy agency.

The role of Legal Advocacy for Persons with Developmental Disabilities is to protect and advocate for the rights of these persons. The Project staff concentrate on direct representation of people with disabilities, legislative and administrative advocacy, and consumer and professional education and training. A major focus of legal advocacy services is to assure that quality community services are available for people with developmental disabilities.

Legal Advocacy is funded by the Administration on Developmental Disabilities of the United States Department of Health and Human Services, United Way of the Minneapolis Area, Gamble/Skogmos Foundation, and personal contributions.

In Federal Fiscal Year 1988, 502 individuals with developmental disabilities were served. In addition, there were 2,800 individuals represented under the *Welsch* class action suit. The *Welsch* lawsuit was initiated in 1972, and resulted in the eventual placement of more than one thousand persons with developmental disabilities from Minnesota's Regional Treatment Centers.

Client Assistance Project

Section 112 of the Rehabilitation Act of 1973, 29 U.S.C. Section 732, required that the Governor designate a public or private agency to assist clients and potential clients of rehabilitation programs. Governor Rudy Perpich designated the Legal Aid Society of Minneapolis, Inc., to fulfill that function. The Client Assistance Project is funded by a grant from the Rehabilitative Services Administration of the United States Department of Education.

The Client Assistance Project provides information, support, and advocacy services to clients and potential clients of the Division of Rehabilitation Services and State Services for the Blind to ensure that they receive the services and benefits available to them as provided by the Rehabilitation Act of 1973.

In Fiscal Year 1988, there were 472 individuals served by the Client Assistance Program.

Minnesota Mental Health Law Project

The Minnesota Mental Health Law Project is a legal assistance project which protects and advocates for persons with mental illness in Minnesota. The Project works on problems relating to abuse and neglect of persons with mental illness, lack of appropriate individualized treatment or discharge plans, improper seclusion or restraints, violation of rights to confidentiality and privacy, and lack of a safe and healthy environment.

Federal law requires that each state have a system to protect and advocate the rights of persons with mental illness who either are or were inpatients or residents of a care or treatment facility with a problem that occurred within 90 days after discharge. The Minnesota Mental Health Law Project has been designated by Governor Perpich as the Mnnesota Protection and Advocacy agency for persons with mental illness. The Project is funded by the federal government, United Way of the Minneapolis Area, and the McKnight Foundation.

In Federal Fiscal Year 1988, the project served 312 persons.

Office of the Ombudsman for Mental Health and Mental Retardation

The Office of Ombudsman for Mental Health and Mental Retardation was created by the 1987 Minnesota Legislature. This Office has been given a broad mandate to promote the highest attainable standards of treatment, competence, efficiency, and justice for all people receiving care and treatment for mental illness, mental retardation, chemical dependency, or emotional disturbance. The Office reviews complaints from any source concerning the actions of an agency, facility, or program that provides services to these populations. These complaints may deal with individual client concerns or concerns of a more general or systemic nature.

In 1988, there were 2,800 complaints received pertaining to:

Types of Complaints	Percentage of Complaints
Treatment issues	29%
Legal issues	25%
Abuse/neglect	14%
Rights issues	12%
Living conditions	11%
Denial of services	4%
Deaths	4%

Most complaints were originated by clients (n = 1,162) and facility staff (n = 981). Most of the clients were under commitment as mentally ill (35 percent) or developmentally disabled (18 percent).

Social Security Administration

Supplemental Security Income (SSI)

Established by the U.S. Congress in 1972, the SSI program provides a national minimal income floor for people who are aging, have a disability, or are blind. This income maintenance program is designed to assist individuals with disabilities who may be below specified income and resource limits. People with low incomes and resources age 65 and over are eligible. Persons 18 and older may receive SSI if a physical or mental disability is expected to prevent a person from working, and if the disability is expected to last at least 12 months or result in death. A child (under 18 years) with a disability may also receive SSI if the disability is as severe as one that would keep an adult from working and is expected to last at least 12 months or result in death.

A person who lives independently can receive as much as $368.00 a month from SSI (or $553.00 for a couple if both persons are eligible). The level of payment will increase in January 1990. Individuals living in group homes are often considered to be living independently and can qualify for the payment rate. People living in someone else's household, such as a person with a developmental disability living with his or her natural parents, qualify for a lower amount. Parental income and resources are not considered in determining eligibility in this type of situation.

In addition to receiving the income under SSI, recipients automatically are eligible for food stamps and Medicaid.

In 1987, the following numbers of people received SSI payments in Minnesota, receiving an approximate total of $79,908,000:

	Number of People	Amount of Payments
Persons who are elderly	9,593	$14,482,000
Persons who are blind	629	1,566,000
Persons with a disability	25,426	63,860,000
TOTAL	35,648	$79,908,000

Source: Social Security Administration, 1988, *Social Security Bulletin: Annual Statistical Supplement*, p. 317.

In a national survey conducted by the Villars Foundation (April 1989) in Washington, D.C., it was documented that three out of five Minnesotans eligible for Supplemental Security Income do not receive it, primarily because they are unaware it exists or that they qualify. The survey revealed that 51 percent of the 4 million people who would be eligible nationally took advantage of the SSI program. In Minnesota, only 39 percent of 33,900 eligible people were receiving SSI.

Social Security Disability Insurance (SSDI)

SSDI provides monthly benefits for workers and eligible members of their family if an illness or injury is expected to keep the worker from working for a year or longer. Under Social Security, the definition of disability is related to the ability to work. This definition requires total disability and is somewhat stricter than the definition of some other programs that may pay benefits in cases of partial disability. Family members may also qualify for disability benefits on the employee's work record, such as:

- An unmarried son or daughter (including step-child, adopted child, and, in some cases, a grandchild) who is under 18 or under 19 if in high school full time;
- An unmarried son or daughter disabled before age 22;
- The disabled worker's spouse who is caring for the worker's child who is under 16 or disabled and also receiving checks; or age 62 or older;
- The disabled worker's widow or widower, payable at age 50; and
- A disabled surviving divorced wife or husband, if the marriage lasted 10 years or longer, with benefits payable at age 50.

State Board of Vocational Technical Education

In recent years technical training has been made available to persons with disabilities in Technical Colleges (TCs). In Minnesota, there are 30 TCs located at 34 locations throughout the state. The TC system is supported by funds from state appropriations, federal aid, and student tuition. The approximate contribution to the system from each of these sources is 68 percent state appropriations, 7 percent federal aid, and 25 percent student tuition.

The occupational programs of the TCs provide students with:

- Initial job training or retraining of the skills necessary for a particular job;
- An opportunity to improve or upgrade current job skills;
- A chance to explore other careers;
- An opportunity for personal or professional development;

Student Population: In Fiscal Year 1988 (ending June 30, 1988), there were 2,258 students with handicapping conditions enrolled in vocational education/postsecondary programs. There may also be a number of students who have handicaps but were listed among the 19,671 students who were classified as "disadvantaged."

Vocational Technical Education State Plan: The following is a partial list of objectives excerpted from the Annual Program Plan (Draft Copy): *Minnesota State Plan for Vocational Technical Education for Fiscal Year 1990 (July 1, 1989, through June 30, 1990).* These aspects of the plan were selected on the basis of those features which directly or indirectly affect persons with developmental and other disabilities:

- Special vocational programs will be designed for students with disabilities.
- Career development and guidance will be provided for all secondary students with disabilities or who are disadvantaged.
- Equal access will be provided for persons who are disabled/disadvantaged in all recruitment, enrollment, program and course offerings, and placement activities.
- Vocational programs, services, and activities for persons with disabilities will be provided in the least restrictive environment whenever appropriate.
- Assessment activities will be implemented for students who are disabled/disadvantaged. Student intake process instruments have been designed to provide a comprehensive base for local student support personnel to match student needs with appropriate support services. These instruments focus upon career, academic, vocational, financial, and personal needs assessments.
- Students who are disabled/disadvantaged who are enrolled in vocational education programs will receive supplemental support services, guidance, counseling, and career development services, and counseling services to enhance transition from school to post-school training.

State Council on Disability

This Council was created by the Minnesota State Legislature in 1973. Consisting of 21 members who are appointed by the Governor, the Council advises the Governor, the Legislature, service providers, and the general public about services, programs, and legislation necessary for people with physical, mental, or emotional disabilities. In addition to promoting interagency coordination and improvement of services and programs, the Council provides information and referral services to individuals and

families seeking services, as well as information about the needs and rights of persons with disabilities to the general public.

The State Council on Disability works cooperatively with the Governor's Planning Council on Developmental Disabilities in several areas such as legislation and policy reform, advocacy, public relations, and coordination of state activities and services.

Governor's Advisory Council on Technology for People with Disabilities

The Governor's Advisory Council on Technology for People with Disabilities is a public-private initiative formed by Governor Rudy Perpich by Executive Order 86-12 in 1987 and Executive Order 89-5 in 1989. The Council, administered by the State Council on Disability, develops public policy on the use of technology for people with disabilities. A specific focus is improving information collection and dissemination, increasing awareness, and encouraging funding, research and development efforts. The 15-member Advisory Council includes representatives from service agencies, people with disabilities, private industry, funding sources, and education systems. Representatives from eight state agencies serve as ex-officio members.

In recent years, there has been a significant acceleration in the rate of technological innovation—new devices and processes that can enhance the daily lives and activities of people with disabilities. An enormous range of technological devices is available to help individuals function more fully in the areas of mobility, communication, and negotiation and control of the environment. In addition, technological devices can be used in educational and vocational settings allowing many individuals to access learning opportunities that had been closed to them in the past.

With the passage of the Technology-Related Assistance for Individuals with Disabilities Act of 1988 (P.L. 100-407) by the United States Congress, the Advisory Council has applied for a three-year grant to establish a statewide system of technology responsive to consumer needs. Minnesota was selected as one of the first nine states to receive a grant.

4.2
State Review Process

There were many new requirements of the states made by Congress in the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 100-146). Such requirements were intended to assist the states in their planning processes as well as to generate meaningful information for state and federal policymakers. Many of these requirements have been accomplished by the Governor's Planning Council, while others are nearing completion, as indicated below:

4.2.1
State Plan Review

Requirement: The state shall review the eligibility for and scope of services provided to persons with developmental disabilities and their families [Section 122(b)(5)(C)(i)]; [Section 122(f)(i)]; and [Section 122(b)(5)(C)].

Compliance: The Minnesota Governor's Planning Council has: (a) collected and analyzed existing reports, plans, and original materials which identify the agencies (including public assistance) that receive federal and state funds to provide services to people with developmental disabilities. Eligibility requirements were collected and analyzed for each service and the extent and scope of services were documented.

Requirement: Each State Planning Council shall conduct a review and analysis of the effectiveness of, and consumer satisfaction with, the functions performed by, and services provided or paid for from federal and state funds by, each of the state agencies (including public assistance) responsible for performing functions for, and providing services to, all persons with developmental disabilities in the state. Such review and analysis shall be based upon a survey of a representative sample of persons with developmental disabilities receiving services from each agency and their families if appropriate [Section 122(f)(C)(2).

Compliance: A consumer survey was conducted based on several national survey forms developed for previous studies. A request for volunteers to participate in the survey was widely disseminated. In March 1988, over 1,300 volunteer survey forms were distributed to 11 organizations which in turn mailed them to their members. Another 2,500 volunteer forms were included in each of three monthly newsletters. A news release soliciting volunteers for the consumer survey received widespread distribution through local newspapers and other organizational newsletters.

Survey results documented needs and levels of satisfaction regarding: case management services, community living, education, transportation, health care services, interactions with professionals, early intervention services, and employment.

Requirement: The state shall review the extent to which existing priority area activities are responsive to the needs of persons with developmental disabilities and their families [Section 122(b)(5)(i)]; and [Section 122(b)(5)(A)].

Compliance: The priority activities identified in the existing plan, *Developmental Disabilities Three-Year State Plan* (October 1, 1986–September 30, 1989), focused on case management services and supported employment.

The Council's goal for case management for federal fiscal years (FFYs) 1987 to 1989 was:

> *By 1989, the efficiency, responsiveness, and measurable effectiveness of case management services for persons with developmental disabilities will increase.*

During this three-year period the Council made the following grants:

University of Minnesota, Institute on Community Integration

Project Funding:

	Federal	State
FFY 1987:	$50,000	$17,252.

The grant enabled the collection of baseline data about case management in Minnesota. The Institute sought information about the practice of case management by county agencies, barriers to effective case management, and identification of programs perceived as effective by clients, parents, guardians, providers, and case managers. A written survey was developed, field tested and mailed to nine target groups. The original mailing included 1,771 questionnaires. A mail and telephone follow-up eventually produced a return of 770, or 43 percent.

The results of the survey were tabulated and published in a 320 page report and a smaller executive summary *Policy Analysis Paper No. 24: Minnesota Case Management Study: Executive Summary*. This project produced the first comprehensive picture of the practice of case management for persons with developmental disabilities in Minnesota. (See summary in Section 7.2.2.)

Metropolitan Council:

Project Funding:

	Federal	State
FFY 1987:	$53,300	$28,700
FFY 1988:	$60,500	$25,500
FFY 1989:	$45,092	$20,208.

In FFY 1987, the Metropolitan Council focused on the interdisciplinary team within the case management process. Based on a survey of "key informants," a manual, a videotape, and an audiotape were produced, tested, published, and disseminated. Entitled *The Case Management Team: Building Community Connections,* this set of materials has become the basic "how to" manual for parents, consumers, and professionals. Demand for the manual has surpassed the original distribution of 600 copies, and has required reprinting. Copies of the audiotapes and videotapes are kept in the Council's resource library where they are available for loan. Eighty-five loans of the tapes were made in the first year.

In FFY 1988, the Metropolitan Council focused on the assessment and planning functions of the case management process. "Personal Futures Planning" was selected as the strategy to accomplish the grant objectives. The grant resulted in the production and dissemination of a videotape and a manual entitled *It's Never Too Early, It's Never Too Late.* Ten thousand copies have been disseminated and demand has required additional printing. The Department of Human Services purchased and distributed one copy to each county for use by county case managers.

The material does not teach personal futures planning techniques; rather, it acquaints the viewer and reader with state-of-the-art ideas.

During the process of preparing the manual and videotape, two county case managers, two families, thirteen staff at Regional Treatment Centers, and six staff from community provider organizations were involved in personal futures planning. During the training process two persons with disabilities had personal futures plans prepared. One has changed employment and is planning to move from a group home to her own home; the other is planning to move from a Regional Treatment Center to live with her sister in the community.

In FFY 1989, the Metropolitan Council focused on training of trainers in the personal futures planning process. It is expected that twelve persons will be trained in the techniques of personal futures planning and will, in turn, train others throughout Minnesota.

Dakota and Itasca Counties:

Project Funding:

	Federal	State
FFY 1987:	$ 96,500	$245,986
FFY 1988:	$ 75,000	$ 25,000
FFY 1989:	$100,200	$ 43,050

The FFY 1987 project funded a cooperative effort between Dakota and Itasca counties to develop a microcomputer-based information system that could assist county case managers in managing their case load. The product was called the Case Management System (CMS). Dakota County is a rapidly growing suburban development of the Minneapolis-St. Paul Metropolitan Area. In contrast, Itasca County is a rural county in northern Minnesota. Any system that worked in these

two counties, would work in any county in Minnesota. At the end of the first year the project had produced a rough microcomputer-based information system that was being used by the two counties.

In FFY 1988, the two counties received a single grant to solve problems in the CMS and to add enhancements. Also included was the development of an "expert system" for use within the case management process. As the CMS was being "debugged," it became apparent that other counties were interested in acquiring the system for their own use. This required the preparation of instructional material about CMS.

The expert system was completed focusing on the county waiver screening document. In the process, the Department of Human Services expressed concerns, which were resolved by the counties and the Council. The result has been extremely beneficial to all counties in Minnesota.

In FFY 1989, Dakota and Itasca counties received a grant to assist four additional counties to replicate the CMS system. Part of this project included the establishment of a "User Group" responsible for training staff in counties new to the CMS and for dissemination of the CMS after the end of the fiscal year.

At this time, CMS is installed and in use in six of the 87 counties in Minnesota. Sufficient interest has been shown by other counties to estimate that at least 20 additional counties will install the system in the near future. Based on evaluation results, use of CMS by the case managers has resulted in a higher level of service to the persons with whom they work. In some counties the case managers use laptop computers that enable them to retrieve data during meetings thereby expediting decisions about services.

Chippewa, Olmsted, Pine, and St. Louis Counties

Project Funding:

	Federal	State
FFY 1989:	$52,000	$57,094

In FFY 1989, the Council asked for applications from counties interested in replicating the County Case Manager System (CMS). Five counties responded, and four were awarded grants. The CMS is now installed and in use in these four counties. While not every case manager in all four counties has been trained in its use, the majority of case managers in the four counties are actively using the system. One case manager who has been using the system for about two years was heard to say, "I will quit my job before I will give up the use of CMS."

Association for Retarded Citizens (ARC)—Suburban

Project Funding:

	Federal	State
FFY 1987:	$50,742	$16,917
FFY 1988:	$54,771	$18,257
FFY 1989:	$59,791	$47,297

In FFY 1987, ARC began what came to be known as the "Parent Case Manager Project." The concept was simple—give parents information and training that enable them to take a more active role in decisions about services provided to members of their families. During the project year, 12 parents became parent case managers.

An evaluation completed at the end of the year compared the 12 parent case managers with a control group of 9 parents who had not received training. Results indicated that parent case managers had increased the average number of services being received per family by 3.6, while the increase in the control group was 2.8. Of even greater importance were the relationships that had been established between the parents and the case managers. These relationships resulted in virtually unqualified endorsements for the project from the case managers. The impact of this project went beyond the participants. As the parents advocated for their own family members, other families benefitted from their efforts. For example, when one parent obtained services from the school district, the school district had to offer the same services to all students with disabilities.

In FFY 1988, the program was expanded with the training of five additional parent case managers and the addition of five consumer case managers. The impact was similar to the experience of the first year. This grant recipient also investigated the possibility of developing a voucher system for Minnesota as a logical follow-up to the parent/consumer case manager concept. A voucher system represents the ultimate situation where the parent or consumer has control over the purchase of services.

In FFY 1989, ARC-Suburban focused on developing the voucher system. The Council has also offered other organizations in Minnesota the opportunity to replicate the parent/consumer case manager project. The Institute on Community Integration applied and will replicate the project in several rural counties.

Association for Retarded Citizens—Minnesota (Volunteer Monitoring Project)

Project Funding:

	Federal	State
FFY 1987:	$49,935	$18,000
FFY 1988:	$75,000	$26,860
FFY 1989:	$36,690	$20,110

In FFY 1987, ARC-Minnesota initiated a system of volunteers to monitor residential and other settings for quality of life issues. During this grant year training materials, monitoring tools, and recruitment techniques were developed. Contacts were made with providers to enlist their support. Eighteen volunteers were recruited and trained in monitoring techniques. Efforts were made to obtain willing providers for initial monitoring efforts. This proved more difficult than anticipated. As a result no monitoring was completed during this project year.

In FFY 1988, monitoring began. During the year, 14 additional volunteers were trained and volunteer monitors visited ten residential facilities in five different communities. Each facility was visited three to four times, for an average of two hours, by a team of two persons. These visits resulted in suggestions that helped improve the quality of life for persons living in the facilities. Examples of changes include: private visiting areas for residents, greater privacy in bedrooms and bathrooms, greater involvement by the residents in the decisionmaking process, and increased integrated leisure activities.

Monitoring continued in FY 1989 and attempts were made to expand coverage and to establish this effort as an ongoing program. At this time data are not available on the number of monitoring visits or results of the visits.

Association for Retarded Citizens—Minnesota (Peer Advocacy Project)

Project Funding:

	Federal	State
FFY 1988:	$34,729	$14,585
FFY 1989:	$17,000	$ 9,672

In FFY 1988, this project trained parents of children with disabilities to be peer advocates. As a peer advocate, parents assist other parents in obtaining quality case management services. Training covers: normalization, state-of-the-art services, case management, evaluating individual plans, and advocacy. Four communities in rural Minnesota were selected as training sites. Publicity regarding the workshops was distributed and the workshops conducted. Attendance at the workshops varied from 10 to 25. Project staff found it necessary to work with providers and county case managers to help them understand the role peer advocates will play as part of the system. In total, 53 persons were trained.

In FFY 1989, this program was expanded into five new areas, with an emphasis on rural geographic location. The Council believed that the program needed to reach parents and others in areas not normally covered by workshops. This has proved to be both an advantage and a disadvantage. Participants in the workshops are enthusiastic and motivated, but logistics are a problem. A final count of the number of persons attending the workshops and completing the training is not available at this time.

Minnesota State Planning Agency (Partners in Policymaking)

Project Funding:

	Federal	State
FFY 1987:	$100,000	$92,669
FFY 1988:	$100,000	$69,227
FFY 1989:	$ 99,980	$32,676

In FFY 1987, the grant was used to contract with Government Training Service. In FFYs 1988 and 1989, the grant was used to contract with the University of Minnesota, Institute on Community Integration. In all three years the contractors delivered the same programs. The program was designed to provide leadership training for parents of young children and individuals with disabilities. The program consisted of eight two-day sessions on state-of-the-art issues and exercises on how to influence decision making.

Subjects covered in the eight sessions include: Historical Perspective of the Advocacy Movement; Quality, Integrated Education; County Issues; Federal Issues; State Issues; Nonaversive Behavior Approaches and Technology; Integration and Advocacy; and Advocacy Organizations. When accepted into the program, participants are asked to sign an agreement in which they commit to attend all sessions and to do "homework" between sessions. Homework can include reading material, writing or calling elected officials, attending meetings of policy boards, or applying for positions on state or local boards or councils.

Participants were recruited from all geographic areas of the state, from all economic groups, from all ethnic groups, and representing all types of disabilities. In 1987, 35 persons participated; and of these participants, 5 were individuals with disabilities. In FFY 1988, 36 persons participated; of these participants, 4 were individuals with

disabilities. In 1989, 35 persons are participating; and of these participants, 6 are individuals with disabilities.

Following completion of the program, participants from years one and two achieved the following: 50 newspaper articles including profiles of the participants, 5 radio and television appearances, 70 appointments to state and local commissions or committees, more than 500 letters and more than 150 visits to local, state, or federal officials, testimony at 15 local, state or federal hearings, invitations to speak at five university classes, and numerous instances of improved or expanded services. The same program was used in each of the three years, with slight modifications to improve effectiveness.

Minnesota State Planning Agency (Training Initiative)

Project Funding:

	Federal
FFY 1988:	$100,000
FFY 1989:	$100,000

In FFYs 1988 and 1989, the grant was used to contract with the University of Minnesota, Institute on Community Integration to develop a program for training direct care staff and case managers. The program goal was to establish preservice ıd and in-service offerings at institutions of higher education throughout Minnesota at for staff working with persons with developmental disabilities

The first year (FFY 1988) was spent interviewing representative "stake holders" organizations including: provider organizations, Community Colleges, Higher Education Coordinating Board, University of Minnesota, Technical Colleges, Department of Human Services, Department of Jobs and Training, Division of Rehabilitation Services, and consumer and advocacy organizations.

A large part of the second year (FFY 1989) was devoted to the development of five modules that form the core courses. These modules cover the following areas: Augmentative Communication; Physical Disabilities; Nonaversive Approaches to Behavior Management; Individual Plans and Planning; and Technological Adaptations. These modules meet the new training requirements included in DHS rules for community facilities and waivered services.

University of Minnesota (A New Way of Thinking)

Project Funding:

	Federal	State
FFY 1987:	$91,862	$8,866

This grant enabled the publication of a policy briefing book expressing the Council's position on many issues in the field of developmental disabilities. *A New Way of Thinking* has been instrumental in presenting state-of-the-art ideas to persons throughout Minnesota, the nation, and internationally. Over 30,000 copies have been printed and disseminated. It has been translated and printed in Japanese for dissemination in Japan. (See summary in Section 7.2.3.)

During FFYs 1987 to 1989, the Council also made the following grants for employment activities:

Minnesota State Planning Agency

Project Funding:

	Federal	State
FFY 1987:	$39,850	$ -0-
FFY 1988:	$30,000	$10,000 (DHS)
FFY 1989:	$30,000	$12,000 (DHS)
		$90,000 (DRS)

In FFY 1987, the grant was used to contract with the Hubert H. Humphrey Institute of Public Affairs for a study of alternatives relating to funding supported employment in the Community. The report will be published as:

Policy Analysis Paper No. 29: Financing of Supported Employment for Persons with Severe Disabilities.

In FFY 1988, the grant was used to carry out research about community-based employment in Minnesota. A survey was sent to all day training and habilitation centers asking for information on the number of persons placed in the community, the number of hours worked, the amount earned, and the nature of the job. Follow-up mailings and phone calls ensured a high rate of return. The results of this survey were published in:

Policy Analysis Paper No. 27: Supported Employment: Review of Grant Recipients and 1986 DAC Data. (1989, March 31). (See summary in Section 7.2.2.)

In FFY 1989, the grant was used to assist the Department of Jobs and Training, Division of Rehabilitation Services (DRS) to develop a training program for job coaches. An interagency agreement was prepared between DRS and the State Planning Agency that will result in the development of a 30 hour curriculum for training job coaches. The intent of this project is to provide more qualified job coaches and to reduce turnover.

Requirement: The state shall review the process for analyzing data collected by the state education agency under Section 618 (b)(3) of the Education of All Handicapped Children Act [Section 122(b)(5)(c)].

Compliance: In addition to Section 4.1, above, the Governor's Planning Council has: (a) analyzed the data collected in the review of eligibility requirements, extent, scope, and effectiveness of services, as described above; (b) participated on the State Transition Interagency Committee; and (c) participated on an advisory committee to the Minnesota Institute on Community Integration, which has designed and field tested a data collection system for ongoing follow-up of students after leaving the public education system.

4.2.2
Review of Other State Plans

Requirement: The state shall review the extent and scope of services being provided or to be provided to persons with developmental disabilities under such other state plans or federally assisted state programs that the state conducts and in which persons with programs relating to education, job training, vocational rehabilitation, public assistance, medical assistance, social services, maternal and child health, aging, programs for children with special health care needs, housing, comprehensive health and mental health, and such other plans as the Secretary may specify [Section 122(b)(2) (C)(i)].

Compliance: See Section 4.1 above.

4.2.3
Statwide Service System Review

Requirement: Each State Planning Council shall convene public forums, after the provision of notice within the state, in order to:

- Present the findings of the reviews and analyses prepared under paragraphs (1) and (2);
- Obtain comments from all interested persons in the state regarding the unserved and underserved populations of persons with developmental disabilities which result from physical impairment, mental impairment, or a combination of physical and mental impairments; and
- Recommend means to remove barriers to services for persons with developmental disabilities and to connect such services to existing state agencies by recommending the designation of one or more state agencies, as appropriate, to be responsible for the provisions and coordination of such services [Section 122(b)(3)].

Requirement: By January 1990, each State Planning Council shall prepare and transmit to the Governor of the state and the legislature of the state a final written report concerning the review and analyses conducted under paragraphs (1) and (2). The report shall contain recommendations by the State Planning Council concerning:

- The most appropriate agency or agencies of the state to be designated as responsible for the provision and coordination of services for persons with developmental disabilities who are traditionally underserved, such as persons with developmental disabilities attributable to physical impairments, persons with developmental disabilities attributable to a combination of physical and mental impairments, and such other subpopulations of persons with developmental disabilities (including minorities) as the State Planning Council may identify; and
- the steps to be taken to include the data and recommendations obtained, through the conduct of the reviews and analyses under paragraphs (1) and (2) and the preparation of the report required by this paragraph, in the State Planning Council's ongoing advocacy, public policy, and model service demonstration activities [Section 122(f)(4)].

Requirement: By January 15, 1990, the Governor of each state shall submit to the Secretary a copy of the report required by Paragraph (4). By April, the Secretary shall transmit a summary of such reports to the appropriate committees of the Congress [Section(f)(5)].

Compliance: Beginning December 1987, the Developmental Disabilities Council and staff implemented a work plan that addressed each of the new planning requirements. The activities of this work plan— specifically the results of public forums held across the state and two Council retreats held August 3, 1988, and October 5, 1988—led the Council to conclude that a systemic problem found in all priority areas was the **lack of responsiveness and accountability to people with developmental disabilities.** On October 5, 1988, this prevalent theme of **accountability** was adopted by the Governor's Planning Council on Developmental Disabilities as the priority area for the two-year planning cycle beginning October 1, 1989, and ending September 30, 1991.

The 1990 reports will be prepared, approved, and submitted according to federal requirements.

Plan Revisions

5.1
Priority Area

The Minnesota Governor's Planning Council on Developmental Disabilities has selected the option of a "State Priority Area Activity," which was defined in the Developmental Disabilities Assistance and Bill of Rights Act as:

> *Activities to increase the capacities and resources of public and private nonprofit entities and others to develop a system for providing specialized services or special adaptations of generic services or other assistance which responds to the needs and capabilities of persons with developmental disabilities and their families and to enhance coordination among entities [Section 102(9)(A)].*

The Council's selection of major concerns for this two-year plan was shaped by several factors: awareness of federally mandated responsibilities under Public Law 100-146; assessment of statewide needs in each priority area (including the sponsorship of public forums; conducting policy analysis studies; conducting a study of the eligibility for and scope of services provided to persons with developmental disabilities and their families; and collecting input from a consumer survey); final selection of a priority area; and recognition of decision making processes that affect service delivery in the chosen priority area. Employment is a mandatory priority.

The general goal, as selected by the Minnesota Governor's Planning Council is:

> *Increase accountability to individuals with developmental disabilities of all ages to improve independence, productivity, and integration into the community.*

Rationale

The question of how to achieve community integration for people with developmental disabilities was considered by leaders from throughout the country at a National Leadership Institute on Community Integration for People with Developmental Disabilities in Washington, DC, on November 21 and 22, 1988. Several significant themes emerged from the discussions:

- It is a reality in a growing number of communities that people with developmental disabilities can live, work, and go to school in typical settings. This policy direction is supported by a steadily growing body of research and practical experience.
- As a future priority, attention must be directed toward helping people with developmental disabilities to achieve full integration and participation in the community—not merely to help them to be in the community, but to be part of the community as well.
- While "islands of excellence" can be found across the country, programs in most states and communities fall far short of the standards set by the best programs.
- An insufficient policy and economic base exists to support community integration efforts. Federal and state policies and funding mechanisms continue to support segregation rather than integration for people with developmental disabilities. Public policy lags significantly behind the "state-of-the-art" and, in many cases, threatens to circumscribe further progress. (The Research and Training Center on Community Integration, 1989, p.3)

Gerben DaJong (1983), in exploring the reasons why persons with disabilities in general encounter as many obstacles, if not outright rejection, saw the cause in the broad general scene. In an article on "Physical Disability and Public Policy," he wrote:

> *The ultimate and most pervasive of environmental barriers are the attitudinal ones, particularly the view that (people with disabilities) are helpless. There is now more than enough experience to indicate that (people with disabilities), with appropriate environmental support, lead full and independent lives. Without the removal of attitudinal barriers, the disability legislation of the past decade will not realize its full promise. (cited in Perske, 1989, p. 24)*

Speaking at the National Conference on Self-Determination by Persons with Disabilities (Perske, 1989), Gunnar Dybwad provided this challenge:

> *To achieve such a basic change in attitude will take. . .the effective, long-range influencing of public policy on all levels of government, legislative, executive, and judicial—**and the action has to come from the persons with disabilities themselves.** (p. 25, emphasis added)*

The fundamental issues of empowerment for individuals with developmental disabilities involve possessing the **information** necessary to make choices, providing **advocacy** and tools for organizing to help gain access to supports or adapting those supports to best meet needs, and using positive approaches in **building communities** by working with a full range of groups to achieve integration.

5.2
Goals, Objectives, and Funding

5.2.1
Goals and Objectives

The following activities are intended to fulfill the intent of Public Law 100-146, Sections 122(b)(2)(A) and 122(b)(5)(D)(i):

Goals

During the period covered by the next two-year plan (October 1, 1989 to September 30, 1991) the overall goals of the Council will be:

- To increase accountability to individuals with developmental disabilities of all ages by building community capacity to support individuals; and
- To increase accountability to individuals with developmental disabilities of all ages by changing state policies to be more responsive to individuals who are unserved or underserved.

Two-Year Objectives

- By September 1991, there will be improved individual planning processes that are accountable to the individual; based on informed decision making by the individual; and enable the individual to hold the service provider accountable for the outcomes identified in the plan.
- By September 1991, 60 young adults and adults with disabilities who represent the interests of unserved and underserved will have completed a one year Partners in

Policymaking program and 25 will have completed internship placements in government offices.
- By September 1991, self-advocacy groups for unserved and underserved will be organized in at least 20 percent of the counties.
- By September 1991, there will be documented examples of improved access to generic services in six communities.
- By September 1991, there will be legislative change and additional funding to support individuals who are unserved and underserved.

Priority Area Activities: Consistent with the testimony at the public forums and the goals and objectives of the Council, three funding categories have been identified:

- **Improved Individual Planning:** (a) to improve accountability by increasing the quality of individual planning throughout Minnesota for individuals of all ages and types of disabilities; (b) to enable persons with disabilities to participate more effectively during individual planning sessions; and (c) to provide persons involved in individual planning, such as case managers, with material that will help them to evaluate the process and outcomes of individual planning.
- **Advocacy Training and Support:** to increase the empowerment of individuals with disabilities and create self-advocacy organizations to assist individuals who are unserved and underserved.
- **Building Communities:** to support the process of building communities for persons with developmental disabilities. In order for individuals with disabilities to become full participants in the community, it is necessary to acquaint policy makers, public officials, and generic organizations with the factors that are preventing full participation and to enlist them in the efforts to achieve full participation.

Plan Year Objectives: During the next year, the Council intends:

- To increase the number of parents and individuals with developmental disabilities, as well as other family members, who are able to advocate for themselves;
- To increase the quality of individual plans;
- To test the concept of using a voucher for purchase of services;
- To increase the quality of leisure time for youth with disabilities; and
- To increase the number of self-advocates and self-advocacy organizations.

Plan Year Objective Activities: The Objectives will be accomplished by the following activities.

Improving Self-Advocacy/Leadership Training:

- Advocating Change Together and People First will receive a grant to establish two new chapters of consumer organizations in Minnesota locations where no self-advocacy organizations currently exist for persons with disabilities. The grant provides for the necessary training to ensure the viability of the new chapters.
- Institute on Community Integration, University of Minnesota, will receive a grant to replicate the Parent Case Manager program with 45 parents in areas of Minnesota where parents have not had access to this program. Parents will receive training in a number of areas to enable them to be more involved in selecting and contracting for services for the family member who is developmentally disabled.
- World Institute on Disability will receive a grant to replicate the Partners in Policymaking project for 35 persons, most of whom will be consumers. Participants will be recruited from throughout Minnesota and attention will be paid to obtaining a mix of age, sex, place of residence, economic status, ethnic

groups, and disability. Eight two-day sessions will be delivered to the participants in order to provide information on leadership training, and state-of-the-art services to persons with disabilities.

Community Integration/Personal Futures Planning:

- ARC—St. Paul will receive a grant to examine the use of "free-time" by 14-21 year old youths with disabilities with the aim of achieving a better coordinated community-based leisure service system that is open, integrated, and accountable to persons with developmental disabilities and their families. Under the guidance of an advisory council, generic program staff will receive technical assistance and support to make programs and settings accessible. Youth with developmental disabilities and their families will receive empowerment training. A model process detailing these aand other approaches will be published.
- Human Services Research and Development Center will receive a grant to identify six individuals in each of five county or multi-county areas and institute procedures that attempt to integrate the individuals more fully into their local communities. Staff from local agencies and providers will be used to assist with the project. Personal Futures Planning (PFP) will also be offered at five sites in Greater Minnesota: workshops will be conducted to provide information about PFP; volunteers will be trained to conduct the process with persons with disabilities; and volunteers will be asked to train others in the process.

Demonstration Projects:

- Dakota County Human Services will receive a grant to test a voucher program with ten families who have children with a developmental disability. These families will be given full authority to use County funds already budgeted for them to purchase goods and services, enabling the children and families to manage their own lives.

Employment Activities:

- Epilepsy Foundation of Minnesota will receive a grant that will enable the Foundation to expand Training and Placement Services (TAPS) in the Twin Cities Metropolitan Area to minority persons over age 18 who have epilepsy. Outreach will be carried out in the Black and Hispanic communities.
- Kaposia, Inc. will receive a grant to implement the Career Planning Process with ten persons in the Twin Cities Metropolitan Area and ten persons in areas of Minnesota where this program has not been available. The Career Planning Process is a variation of Personal Futures Planning that focuses on employment and career planning. Workshops and informational meetings will be held and staff in five agencies will be trained in the use of this technique.

Community Building:

- The State Planning Agency will receive a grant to improve monitoring and technical assistance for potential applicants and grant recipients in the area of community building.

Education of Policymakers:

- The State Planning Agency will receive a grant for the purpose of making publications available to thousands of people throughout Minnesota and the country.

Projected Plan Year Funding:	Source	Amount
	Federal	$602,931
	Local	$201,000
	TOTAL	$803,931

Priority Area Activities: These activities will include:

- Development of model policies and procedures;
- Presentation of information, models, funding, conclusions, and recommendations to policymakers.
- Training of day program staff to enable development of Individual Career Plans.
- Use of a voucher in a test county.
- Work with youth who have disabilities in the city of St. Paul to increase quality use of leisure time.
- Develop Personal Future Plans for persons with disabilities.
- Train parents to participate more fully in the case management process.
- Work with self-advocates in underserved areas of the state.
- Provide leadership training to 35 persons with disabilities, their families and guardians.
- Work with persons with epilepsy who are also members of two minority communities, to increase the level and length of employment.

5.2.2
Budget Data

Table 12
Plan of Projected Total Funding by Priority Area and Mandated Activities

PRIORITY AREA AND MANDATED ACTIVITIES	TOTAL PROJECTED FUNDING
Federal Priority Areas:	
• Employment	$ 76,226
• Community Living	0
• Child Development	0
• Case Management	0
State Priority Area:	
• Accountability to Individuals and Families	643,705
• Priority Area and Mandate Activities	34,000
• 1990 Report Activities (Publication)	50,000
TOTAL COST OF ACTIVITIES	$803,931

Table 13
Projected Federal and Matching Funding Plan

ACTIVITIES FUNDED	FEDERAL SHARE	MINNESOTA SHARE	TOTAL PROJECTED FUNDING
Priority Area and Mandate Activities:			
• In Nonpoverty Areas	$602,931	$201,000	$ 803,931
• In Poverty Areas	0	0	0
• Total Activities	602,931	201,000	803,931
Other Activities:			
• Planning, Coordinating, and Advocacy	311,154	104,000	415,154
• Plan Administration	13,500	13,500	27,000
TOTAL PROJECTED FUNDING	$927,585	$318,500	$1,246,085

6.1
Program Related

6.1.1

The state assures that appropriate financial and technical assistance is provided to agencies or entities serving persons with developmental disabilities who are residents of designated rural or urban poverty areas. [Section 122(b) (5)(E) and 45 CFR 1386.30(a)]

6.1.2

The state assures that each program (including programs of any agency, facility, or project): (1) has in effect an habilitation plan for each person with developmental disabilities who receives services from or under the aegis of the program; (2) establish policies and procedures to review annually each habilitation plan (in accordance with the procedures set forth in Section 123(c) of the Act). [Section 123 and 45 CFR 1386.30 (e)(2)]

6.1.3

The state assures that funds paid to the state under Section 125 of the Act will be used to make a significant contribution toward enhancing the independence, productivity, and integration into the community of persons with developmental disabilities. [Section 122(b)(4)(A) and 45 CFR 1386.30(a)]

6.1.4

The state assures that the human rights of all persons with developmental disabilities who are receiving treatment, services, or habilitation under programs assisted under this title will be protected consistent with and in accordance with Section 110 of the Act (relating to the rights of persons with developmental disabilities). [Section 122(b)(6)(C) and 45 CFR 1386.30(e)(3)]

6.1.5

The state assures it has undertaken affirmative steps to assure that participation in programs under this title are individuals generally representative of the population of the state with particular attention to the participation of members of minority groups. [Section 122(b)(6)(D) and 45 CFR 1386.30(a)]

6.1.6

The state assures that there is a system in place to keep records and that such system and procedures provide access by the Secretary, U.S. Department of Health and Human Services, and the State Planning Council. [Section 122(b)(1)(C) and CFR 1386.30(a)]

6.1.7

Assure that funds allotted to the state will be used to complement and augment rather than to duplicate or replace services for persons with developmental disabilities who are eligible for federal assistance from the state progams. [Section 122(b)(2)(C) and 45 CFR 1386.30(a)]

6.1.8

The state assures that the Minnesota Governor's Planning Council on Developmental Disabilities may prepare and approve a budget using amounts paid to the state under Section 125 of the Act to hire such staff and obtain the services of such professional, technical, and clerical personnel (consistent with state law), as the State Planning Council determines to be necessary to carry out its functions under this part of the Act. [Section 124(c)(1)]

6.1.9

The state assures that staff and other personnel of the Minnesota Governor's Planning Council on Developmental Disabilities, while working for the State Planning Council, shall be responsible solely for assisting the State Planning Council in carrying out its duties under this part and shall not be assigned duties by the designated state agency or any other agency or office of the state. [Section 124(C)(2) and 45 CFR 1386.30(c)(1), 1386.30(e)(4)]

6.1.10

The state assures that the state plan was developed jointly by the designated state agency and the State Planning Council. [Section 124(d)(1)]

6.1.11

The state assures that the Minnesota Governor's Planning Council on Developmental Disabilities shall submit to the Secretary, through the Governor, such periodic reports on its activities as the Secretary may reasonably request, and keep such records, and afford such access thereto as the Secretary finds necessary to verify such reports. [Section 124(d)(4) and 45 CFR 1386.32]

6.1.12

The state assures that, if Community Living Arrangements was selected as a priority area activity, there is in effect a plan which reflects fair and equitable arrangements to protect the interests of employees affected by actions under this plan, if any, including arrangements designed to preserve employees' rights and benefits, to provide training and retraining of such employees as necessary, and that maximum efforts will be made to guarantee their continued employment. [Section 122(b)(7)(B)]

6.1.13

The state assures that any services provided under the plan are provided in an individualized manner. [Section 123, Section 122(b)(6)(B) and 45 CFR 1386.30(a)]

6.2
Administrative

6.2.1

The state assures that there is a system in place to keep records and that there are procedures to permit access to them by the Secretary, U.S. Department of Health and Human Services, and the Minnesota Governor's Planning Council on Developmental Disabilities. [Section 122(b)(1)(C) and 45 CFR 1386.30(a)]

6.2.2

The state assures that there are established procedures to assure the proper disbursement of and accounting for federal funds. [Section 122(b)(1)(D) and 45 CFR 1386.30(a), 1386.32, 1386.35]

6.2.3

The state assures that part of the funds paid to the state under Section 125 of the Act will be made available by the state to public or non-profit private entities. [Section 122(b)(4)(B) and 45 CFR 1386.30(a)]

6.2.4

The state assures that not more than 25 percent of the funds paid to the state and expended under Section 125 of the Act will be allocated to the designated state agency for the provision of services by the designated state agency meeting the requirements of Section 122(e) of the Act. [Section 122 (b)(4)(c) and 45 CFR 1386.30(a)]

6.2.5

The state assures that funds paid to the state under Section 125 of the Act will be used to supplement and to increase the level of funds that would otherwise be made available for the purposes for which federal funds are provided and not to supplant such nonfederal funds. [Section 122(b)(4)(D) and 45 CFR 1386.30(a)]

6.2.6

The state assures that there will be reasonable state financial participation in the cost of carrying out the state plan. [Section 122(b)(4)(E) and 45 CFR 1386.30(a)]

6.2.7

The state assures that there are established procedures to provide special financial and technical assistance to agencies or entities serving persons with developmental disabilities who are residents of designated rural or urban poverty areas. [Section 122(b)(5)(E) and 45 CFR 1386.30(a)]

6.2.8

The state assures that buildings used in connection with the programs assisted under the plan will meet standards adapted pursuant to the Architectural Barriers Act of 1968. [Section 122(b)(6)(A)(ii) and 45 CFR 1386.30(a)]

6.2.9

The state assures that it will provide the Minnesota Governor's Planning Council on Developmental Disabilities with a copy of each annual survey report and plan of correction for cited deficiencies prepared pursuant to Section 1902(a)(31) (B) of the Social Security Act with respect to any Intermediate Care Facility for Persons with Mental Retardation in such state within 30 days after the completion of each such report or plan. [Section 122(b)(6)(E) and 45 CFR 1386.30(a)]

6.2.10

The state assures that the process used to determine the designated state agency was selected in accordance with the provisions of Section 122(c) of the Act. [Section 122(b)(8)]

6.2.11

The state assures that programs and facilities operated under the plan meet federal regulatory standards. [Section 122(b)(6)(A)(i) and 45 CFR 1386.30(a)]

6.2.12

The state assures that the staff and other personnel of the Minnesota Governor's Planning Council on Developmental Disabilities work under the sole authority of the Council and are not assigned duties by the Minnesota State Planning Agency, the designated state agency, or any other agency or office of the state. [Section 124(c)(2) and 45 CFR 1386.30 (c)(1) through 1386.30(e)(4)]

7.1
Public Forums—A Summary of Testimony

7.1.1
Introduction

The Governor's Planning Council on Developmental Disabilities (GPCDD) sponsored a series of 16 public forums throughout Minnesota in July 1988.

The purpose of these forums was to obtain testimony from interested individuals, parents, providers, advocates, and government agency representatives regarding priority needs for the next two-year state plan. People were asked to address the four federal priority areas as well as other concerns they might have. Written testimony was also encouraged in the event that people could not attend the meetings held in their area.

The public forums also provided an opportunity to obtain comments from all interested persons in the state regarding unserved and underserved populations of persons with developmental disabilities as well as to gather recommendations that could be included in the 1990 Report to Congress.

These forums were held in cooperation with Legal Advocacy Services for Persons with Developmental Disabilities, of the Minnesota Disability Law Center in Minneapolis, for the purpose of obtaining testimony for the Protection and Advocacy state plan.

7.1.2
Publicity

Publicity announcing 16 public forums was given widespread distribution through: the *DD Information Exchange* (a monthly newsletter with a circulation of 2,900, published by the Developmental Disabilities Program of the Metropolitan Council and the Governor's Planning Council on Developmental Disabilities); a news release sent to 69 daily newspapers, 271 other newspapers, and 188 radio and TV stations in Minnesota; and publication in newsletters of other organizations. Persons were encouraged to provide testimony that would help to direct the Council's selection of priority activities for its two-year state plan.

7.1.3
Sample of Testimony

Testimony at the 16 public forums covered community living, employment, child development, case management, community integration, schools, and other issues such as insurance, technology, legal issues, and personnel training. All statements made at the public hearings and written statements received in the mail were recorded and summarized in a report to the Governor's Planning Council on Developmental Disabilities.

The following statements represent a small sample of what the people of Minnesota had to say at the public forums. A complete report of the testimony is available from the Minnesota Governor's Planning Council on Developmental Disabilities.

Community Living

- There are no alternatives for people with physical disabilities—no Semi-Independent Living Services and no Centers for Independent Living in Virginia and Duluth.
- We need more Centers for Independent Living.
- Employment opportunities often fall apart because there is no housing.
- Programs are needed to help young adults with disabilities make the transition from home to independent living.
- Young adults with epilepsy live in nursing homes because there are no alternatives.

Staffing

- Study human services wages and training needs in community-based programs and formulate plans to assure a well-qualified stable work force of persons who provide services.
- There is a need to train providers in community living. Community living should be used as a creative, flexible, client-specific service.
- Apply what we have learned from the Community Integration Project at Syracuse University.
- The group homes have too much paperwork under the waiver program. We're overregulated. These prevent adequate services to residents.

Respite Care

- Respite care programs simply do not have the funds necessary to serve all of the families in need.
- The county is telling me to put my kids into foster care because I have no help, and I am finding it hard to deal with all three kids. Foster parents are getting respite care before natural parents.

Employment

- We need a partnership with unions.
- Programs in rural areas need to be supported differently than in the metro area.
- There is no supported employment.
- They tell me I'm not disabled enough. I was getting SSI, now they say I'm not disabled.
- We need a variety of ways to create and find employment opportunities.
- I am living in a small community where there are no resources. It's normal to move out of small towns. Therefore, people who need special resources should move to where they can get them.
- Employment is the number one problem for people with epilepsy.

Child Development

- Certainly there's a need for better training of health professionals for better early intervention.
- The schools do not have the resources to maintain the same quality of services as Developmental Achievement Centers. There is a need for better coordination during transition.

Case Management

- It is important for parents to have their name on a waiting list and have all the paperwork completed for the time when they do qualify for services. It is also important to have that waiting list so the state is aware of the need and can plan funding for priority needs.
- Case workers seem to be well meaning and honest but lack knowledge.
- Case managers should have more formal training and an opportunity to know a client.
- How can case managers hold providers accountable if the case manager doesn't know the issues?
- How can a case manager develop good plans and follow through with a caseload of 130?

Community Integration

- "Community" means "where services are, not where the person is from." When some people are placed in the community, they lose friends and support.
- The children's biggest need is friends.
- The priority for Minnesota during the next two-year plan period must emphasize the strengthening of the community-based services system.
- Allow people with disabilities more opportunities to participate. Self-advocacy groups like People First need encouragement and support.
- We have many people coming out of Regional Treatment Centers, but there seems to be little support to accomplish community integration.

Schools

- Existing organizations give moral support, but we need as much direct help in advocacy as we can get. Education must be a top priority.
- We as parents get hysterical because we aren't included and aren't asked to participate during the education process.
- Integration is needed for students with severe levels of mental retardation.
- Schools fail to recognize epilepsy and confuse it with behavior problems.

Other issues

- We are concerned about access to proper medical care and, in particular, the issue of uninsured or underinsured Minnesotans. We support Healthspan and encourage other creative solutions to this problem.
- In discussion with adults and parents of children with disabilities, the feeling of powerlessness is overwhelming when negotiating with case managers, school and health personnel, and bureaucracies. A major portion of the resources of the Governor's Planning Council on Developmental Disabilities should prepare individuals with disabilities and their families for relating to systems.
- Training is needed in coordination of information in public education.
- The needs in community services for persons with developmental disabilities are as wide ranging as are the individual differences.

7.2
Annotated Publication List of the Governor's Planning Council on Developmental Disabilities, State Planning Agency

7.2.1
Policy Analysis Series: Issues Related to Minnesota's State Hospitals

During the 1984 Legislative Session, the Minnesota Legislature mandated the establishment of an Institutional Care and Economic Impact Planning Board to study the feasibility of using state employees in the operation of community-based services and to consider the possible economic effects from consolidation, conversion, or closure of state hospitals (Minn. Stat., Chapter 654, Section 19). A policy was established that deinstitutionalization be carried out in a manner that ensured protection of the interests of employees and communities affected by deinstitutionalization of state hospitals. The Board consisted of commissioners of the departments of Human Services, Administration, Employee Relations, Health, Finance, Veterans Affairs, Corrections, Housing Finance Agency, Economic Security, and Energy and Economic Development and the Director of the State Planning Agency. The Developmental Disabilities Council staff, Minnesota State Planning Agency, was given the responsibility for conducting the study and coordinating the plan.

As requested by the 1984 Legislature, the Institutional Care and Economic Impact Board submitted recommendations and findings to the Legislature on January 31, 1985. The report was contained in eight technical papers entitled *Policy Analysis Series: Issues Related to State Hospitals* and an abbreviated policy briefing publication entitled *Minnesota's State Hospitals: Mental Retardation, Mental Illness, and Chemical Dependency:*

Paper No. 1: Minnesota State Hospital Facilities and Alternative Use. (1985, January). The major focus of this study was an analysis of the general condition of state hospital buildings and potential alternative uses of those buildings. This report summarized information which would aid in determining future disposition, conversion, or consolidation decisions: (1) the physical condition ratings of buildings (i.e., age of buildings, property size, building square footage, physical condition, plumbing condition, and electrical condition); (2) cost considerations of renovations or demolition; (3) surplus property procedures and issues; and (4) the results of a national survey of alternative uses of vacated grounds and buildings.

Regarding the national survey, 43 state agencies reported that they did not save money by using state hospitals for other government uses rather than renting or building other facilities. This was due in large part to the condition and age of the buildings, energy costs, and renovation costs. Of the 31 institutions reported closed nationwide, none had been purchased by private industry. Over half had been converted to other types of government-operated institutions, e.g., corrections, Veteran's, geriatric apartments, college, and religious organizations. This report concluded that specific alternative use decisions will require the active involvement of state, county, and local agencies, and state hospital communities if the economic impact on the community is to be significantly reduced.

Paper No. 2: Minnesota State Hospital Energy Use and Cost. (1985, January). This study compared the use of energy, energy efficiency, and energy cost for each of the eight state hospitals for the years 1979 through 1983. Energy use during this five-year span was marked by rapidly rising fuel prices and attempts to shift to lower price fuel sources. Energy conservation measures recommended in this report

included: utilization of shared savings contracts; use of alternative fuels; purchase of electricity from wholesalers; separate metering of leased or rented buildings to the tenants; identification of surplus buildings for demolition to eliminate heating costs; and installation of improvements such as summer boilers.

Paper No. 3: A Profile of Minnesota State Hospital Employees. (1985, January). This study was directed toward the concern expressed by the Minnesota Legislature as to the effects on the employees should a state hospital close. The Legislature sought specific information about the employees: What is the projected displacement of state hospital employees because of deinstitutionalization; and what is the extent to which displacement can be mitigated through attrition, retirement, retraining, and transfer?

There were over 5,900 people, including part-time and intermittent employees working at the eight state hospitals. Over half of the employees were involved in direct care and were often female. The average wage of direct care personnel was $8.10 per hour, or about $5.00 above minimum wage. The length of service averaged over eight years, and the separation rate varied by location. An estimated 1,100 employees (18.5 percent) would be eligible for retirement during the following five years.

The State Planning Agency conducted a survey of state hospital employees to determine future career choices. Most of the 3,154 respondents indicated preference for public sector employment.

This report suggested that creative approaches be considered in making early retirement more attractive rather than incur layoff costs. The portability of pensions may also need to be investigated at the state level to encourage transfer of employees rather than layoffs.

Paper No. 4: The Economic Impact of Minnesota State Hospitals. (1985, January). This report analyzed the impact each state hospital has on the local economy. A large industry such as a state hospital contributes significantly to a community's economy. The smaller the community and less diverse its commercial or industrial base, the greater the impact of any closure or downsizing. Economic impact is not only a function of where employees live and spend their money but also where they work in terms of commuting distance.

Salaries of employees were the most significant factor in estimating community economic impact. The impact changes depended upon the dispersion of employees in a geographic area. Local purchases by the state hospital were a small percentage of local retail sales, due largely to a centralized procurement system.

State hospitals located in rural areas with high unemployment present the most difficulty in terms of developing alternative employment strategies. Retraining and voluntary transfers of employees should be considered as a preferred economic development approach.

Paper No. 5: Public Opinions about State Hospitals. (1985, January). This report summarized testimony received from nine town meetings, over 400 letters, and a toll-free call-in day. Citizens were encouraged to provide input regarding the future of state hospitals and the delivery of services to persons with mental illness, mental retardation, and chemical dependency. Over 5,000 people attended the regional town meetings. Attendance ranged from 260 people at Anoka to 1,500 people at Brainerd. Over 80 separate organizations were represented, and 362 individuals made presentations. In addition, 202 people expressed their opinions

and concerns by phone. Successful public participation was largely attributed to local planning committees which were organized in the eight areas of the state served by the state hospitals, plus one in the metropolitan area.

The overwhelming message of the town meetings, phone calls, and letters were to keep the state hospitals open. There was great fear expressed that people would be "dumped" into the community without support. Public opinions underscored basic criteria for quality programs: (a) provide adequate support for people who are the "most difficult to place"; (b) provide affordable and accessible services; (c) provide services that respond to the special needs of each individual; (d) provide opportunity for families to be involved; (e) provide a range of services in each area; (f) provide coordination, follow-up, and monitoring; and (g) provide staff who are competent, caring, and trained. The study concluded that there was little doubt that any change in the state hospital system would have direct consequences on residents/patients, families, employees, and communities.

Paper No. 6: Residents/Patients in Minnesota State Hospitals. (1985, January). This study was focused on the residents with mental retardation and the patients with mental illness and chemical dependency. Residents with mental retardation and patients with mental illness were analyzed by functional skill levels. Total populations served by the state hospital system had decreased dramatically—from a peak of 16,355 in 1960 to an average daily population of 4,006 in Fiscal Year 1984. By category, the average daily population of the state hospitals in Fiscal Year 1984 was: 1,230 people with mental illness; 2,182 people with mental retardation; and 594 people with chemical dependency.

Residents/patients with mental illness ranged from the severest forms of illness (9 percent) to the least severe symptoms (12 percent). Residents/patients who experienced psychotic episodes, attempted suicide, and abuse of drugs comprised 26 percent of the state hospital population. Ninety percent (90%) of the residents with mental retardation in state hospitals were classified as being severely or profoundly mentally retarded. Generally, this population was highly dependent in several areas of functioning. Residents/patients with chemical dependency were typically young white males who were single, unemployed, had a high school degree or less, were alcohol dependent, and indigent.

The authors concluded that while there were many factors which would influence the future of state hospitals, a very important factor must be the individuals for whom the state hospitals exist.

Paper No. 7: The Cost of Minnesota State Hospitals. (1985, January). This report contained an in-depth review of national literature comparing costs of institutional and community settings for people with mental retardation, the revenue and expenditures of the Minnesota state hospitals, a comparison of community and institutional expenditures during Fiscal Years 1977 through 1984, and a needs approach to cost estimation.

Fifteen years ago, throughout the country the care provided in state hospitals was primarily custodial in nature, and the cost per day was extremely low. Costs increased during the 1970s due to improved staffing as a result of court cases and federal standards. In this same period, people with developmental disabilities were moving to the community. Costs continued to increase in the state hospitals because: (a) the fixed costs increased because of fewer residents; (b) remodeling and construction occurred across the United States to meet federal ICF-MR standards; (c) staffing increased or stayed level in order to reach ratios; (d) unionization of public employees led to higher salaries; (e) inflation had an impact; (f) the proportion of

residents with severe/profound mental retardation increased as people with fewer disabilities left the state hospitals; and (g) indirect costs were added such as overhead and other state administrative costs in order to maximize federal financial participation.

In Fiscal Year 1984, the total operating expenditure for the entire state hospital system in Minnesota was $149,498,251. Staff salaries, which included employee benefits, represented the largest object classification at $128,433,135 or 85 percent of the total operating expenditure. The statewide average hospital operating cost of care for one resident/patient for one year amounted to $37,317. Reimbursements in Fiscal Year 1984 totaled $120,594,420 from all sources. The largest source was the federal share of Medical Assistance, $52,656,694 or 43.7 percent. The second largest source was the state's own share of Medical Assistance at $46,825,724 or 38.8 percent. County payments amounted to $6,362,510 or 5.3 percent of the total.

The number of community group homes in Minnesota have increased dramatically. Since 1980 in Minnesota, expenditures for community services have exceeded state hospital services. In Fiscal Year 1984, $130 million was designated for community services (excluding SSI/SSDI and special education) and $95 million was allocated for state hospital services.

This report documented the difficulties of cost comparisons and outlined the various reasons why average per diem rates between state hospitals and community facilities are incomparable: (a) costs vary by type of resident (age, level of independence, services needed, and staffing needed), e.g., services to children and to persons with severe disabilities are more costly; (b) per diems do not contain the same items;(c) no standard chart of accounts or cost accounting system exists in community programs; (d) determination of costs vary in outcomes among cost studies, e.g., reimbursable cost reporting, average per person costs, fixed and variable costs, units costs, and needs approach; and (e) geographic location, size of population served, staff ratios, and special certification.

Paper No. 8: Options and Recommendations for the Minnesota State Hospital System. (1985, January). This report presented several options and a final set of recommendations approved by the Institutional Care and Economic Impact Planning Board. Options considered in the report were:

(1) Maintain all state hospitals but reduce staff complement in the mental retardation units and increase staff complement in the mental illness units;
(2) Decentralize the state hospitals and begin state-operated, community-based services;
(3) Increase efficiency and introduce elements of competition in all state hospitals; and
(4) Closure of one or more state hospitals.

Analysis of each option took into consideration possible effects upon residents/patients and families, employees, costs, and economic impacts on communities.

Recommendations for the 1985 Legislature included:

(1) Downsizing of the mental retardation units should occur in the 1986-1987 biennium with emphasis on natural attrition of staff. Staff ratios should remain in compliance with the *Welsch v. Levine* Consent Decree;
(2) State-operated community services should be developed and tested during the 1986-1987 biennium; and
(3) The efficiency of the current state hospital system should be improved by adding management systems outlined in the section on competition.

Minnesota's State Hospitals: Mental Retardation, Mental Illness, Chemical Dependency. (1985, January). This publication served as the executive summary to *Policy Analysis Series: Issues Related to State Hospitals, Policy Papers No. 1* through 7. Changes over the last two decades were described in terms of reductions in number of people served by state hospitals, philosophy, and methods of treatment. Several tables and graphs presented data from the state hospital *Policy Analysis Series*. The authors noted that the system had reached a point where decisions were required regarding the types and levels of services offered for people with mental illness, mental retardation, and chemical dependency.

7.2.2
Policy Analysis Series: Issues Related to the *Welsch* Consent Decree

The *Welsch v. Levine* Consent Decree was signed in the United States District Court in September 1980. The Consent Decree required the state of Minnesota to substantially reduce the overall population of persons with mental retardation residing in state hospitals by 1987. Provisions of the Consent Decree also addressed the need for improvement of conditions in state hospitals and the development of community-based services for persons with mental retardation who were to be discharged from state hospitals. This *Policy Analysis Series* on the state hospitals presents the findings resulting from various studies conducted by the Governor's Planning Council on Developmental Disabilities, Minnesota State Planning Agency. These studies focused on several of many issues surrounding the process of deinstitutionalization and the dynamics of systems change.

Policy Analysis Paper No. 1: Taxonomy of Issues Surrounding Implementation of the *Welsch v. Noot* Consent Decree. (1981, March 31). This paper outlined the planning issues and problems related to the implementation of the Consent Decree and the agency responsibilities for certain mandated activities. Four major activities were described: (a) planning at federal, state, and county governmental levels; (b) financing deinstitutionalization; (c) administration, licensing, regulating, and monitoring issues; and (d) planning at the individual level.

Policy Analysis Paper No. 2: The Size of Community Residential Facilities: Current Guidelines and Implications for Planning. (1981, April 10; revised 1981, August). This paper addressed the types of alternative community living arrangements which must be developed by counties within the context of the normalization principle. Twelve conflicting size guidelines were discussed. Review of literature suggested that size of residential facilities may be an important factor in determining the degree to which normalization has been achieved.

Policy Analysis Paper No. 3: Interagency Cooperation: The Underlying Concepts of Trust, Incentives, Barriers, and Forms of Linkage. (1981, April 14). This paper reviewed both the processes which facilitate and those which discourage interagency cooperation. Available research was summarized regarding the concepts of trust, the differences between cooperation and competition, and barriers to and incentives for cooperation. A variety of possible program linkage structures to facilitate interagency cooperation were presented such as exchanging information, identifying problems, and projects displaying varying degrees of system development. Concrete examples of commonly adopted program linkages were drawn from Project Share's *Dimensions of Services Integration*. Interagency cooperation was identified as being essential to the implementation of the Consent Decree.

Policy Analysis Paper No. 4: Cost Function Analysis of Minnesota Intermediate Care Facilities for Mentally Retarded (ICF-MR) Per Diems. (1981, September 1). Based on the results of a multiple regression analysis, this report suggested that eight variables were statistically significant determinants of per diem rates: (a) staff-to-resident ratio; (b) number of nonambulatory residents; (c) years of operation of residential facility; (d) average age of residents; (e) profit/nonprofit status of facility; (f) facility size; (g) family owned and operated facilities; and (h) licensed capacity. Data suggested that smaller residential facilities were not incompatible with cost considerations nor were they inconsistent with state policy and the objectives specified in the *Welsch* Consent Decree.

Policy Analysis Paper No. 5: Admissions/Readmissions to State Hospitals. (1981, August 31). An analysis of state hospital admission and readmission reports indicated that: (a) approximately 80 percent of the admissions from family homes were for parental relief and that had these services been available in the community, many of these short-term informal admissions might have been avoided; and (b) nearly 60 percent of the informal admissions (other than respite care) specifically mentioned a lack of appropriate community support services. Behavior-related problems were a primary reason for admissions in Minnesota.

This report also outlined some essential components for planning of community services, such as: building a capacity within existing services, such as foster homes; adopting a zero reject model; developing a comprehensive array of community services, including age appropriate day programs, respite care, and effective individual program plans; providing adequate staffing and staff training; and assuring that appropriate transition activities were in place in institutional programs which would foster the eventual assimilation of persons with developmental disabilities into community programs.

Policy Analysis Paper No. 6: The Financial Status of Minnesota Developmental Achievement Centers: 1980-1982. (1982, January 11). Data from all 108 developmental achievement centers were collected and analyzed such as: (a) revenue; (b) expenditures; (c) profit/loss; (d) program per diems; (e) transportation per diems; (f) capital assets; (g) building accessibility; (h) licensed capacity; and (i) daily attendance. The total expenditures reported during 1980 and 1981 were $22,702,498 and $25,996,001, respectively. The average daily attendance was 4,219 persons in 1980 and 4,429 persons in 1982.

Policy Analysis Paper No. 7: The Program Status of Minnesota Developmental Achievement Centers: 1980-1982. (1982, January 18). This study of all developmental achievement centers in Minnesota in 1981 focused on personnel and other management issues. Significant findings included: (a) there were 978 persons employed as teachers/instructors and 254 administrators (full-time equivalent); (b) over half of the personnel had at least a four-year college degree; (c) the turnover rate of personnel was 20 percent; (d) the statewide average hourly wage was $7.06; and (e) there were 1,244 out-of-county clients being served by the 106 centers.

Policy Analysis Paper No. 8: The Client Status of Minnesota Developmental Achievement Centers: 1980-1982. (1982, January 26). This report summarized the general characteristics about clients served by the developmental achievement centers in Minnesota from 1980 through 1982. Highlights of this study included: (a) among the 5,150 persons enrolled, over half were between ages 21 and 50 years old, and over 1,200 were of preschool age; (b) while close to 14.0 percent of those enrolled were described as moderately mentally retarded, there were over 28.0

percent with severe, and 10 percent with profound mental retardation; (c) almost half of the clients (45.8 percent) were living in their own natural or adoptive homes, and the remaining number lived in group homes (41.0 percent) or in semi-independent living arrangements (2.0 percent); (d) an estimated 454 clients were ready to move into work activity programs and another 240 ready to move into a sheltered work setting; and (e) there was a waiting list of 499 persons for receiving services at 32 developmental achievement centers.

Policy Analysis Paper No. 9: Summary of Issues, Programs and Clients in Minnesota Developmental Achievement Centers: 1980-1982. (1982, February 10). This report summarized some of the implications associated with the survey reports in the *Policy Analysis Series, No. 6, 7,* and *8.* Problems identified were future staffing levels, support services, client movement, and cutbacks in programs or services. Problems which curtailed the movement of clients were limited community resources, unavailability of appropriate placements, and inadequate support services. Possible solutions to bottlenecks in the system were suggested such as planning, improved coordination between agencies, a refocusing of financial resources, and creation of a viable case management system.

Policy Analysis Paper No. 10: Update to Policy Analysis Series No. 5: Admissions/Readmissions to State Hospitals, June 1, 1981 to December 31, 1981; The Behavior Problem Issue. (1982, April 9). This study added further verification to the premise that behavior problems were the major reasons for admissions and readmissions of persons with developmental disabilities to state hospitals. Another major reason was for the provision of respite care services intended to provide relief to parents or other caregivers.

Policy Analysis Paper No. 11: An Analysis of Minnesota Property Values of Community Intermediate Care Facilities for Mentally Retarded (ICFs-MR). (1982, July 1). This paper dealt with the reality of property values of homes in neighborhoods that contain a group home for persons with mental retardation. Using assessed value as a measure, property values of homes in 14 neighborhoods that contain a group home were analyzed for the year preceding and the year following the establishment of the group home. Changes in property values in these 14 neighborhoods were then compared with changes in property values of homes in similar neighborhoods that did not contain a group home. The findings of this study were consistent with findings of similar research conducted in other parts of the United States: (a) changes in property values were not related to the presence of a group home, and (b) neither the number nor the timing of property transactions in a neighborhood could be related to the establishment of a group home in the neighborhood.

Policy Analysis Paper No. 12: Analysis of Nonformal Training for Personnel Working in the Field of Developmental Disabilities in Minnesota: 1981-1982. (1982, January 3). Based on interviews with 19 individuals from selected public and private agencies and organizations, this study documented the quantity and content of nonformal training events (such as conferences, workshops, and in-service training) that occurred in Minnesota over a two-year period. Some of the findings were: (a) people were generally motivated to continue their education throughout their adult lives; (b) while millions of dollars were invested in nonformal training activities, there were few tangible results such as improved work performance; (c) few training activities were based on a conceptual framework nor were they designed with regard to individual needs and competencies desired; (d) there was a

need for improved coordination and collaboration among agencies; and (e) the strengths of the many existing training resources should be recognized and utilized when designing future comprehensive training systems.

Policy Analysis Paper No. 13: A Survey of Formal Training Programs in Developmental Disabilities in Postsecondary Schools in Minnesota and Adjacent States. (1983, January 3). This paper summarized the findings of a survey of institutions of higher learning in Minnesota and neighboring states. The majority (57 of 89, 64 percent) of educational institutions offered some coursework in developmental disabilities. However, most courses focused on growth and development of children with disabilities. Very little coursework addressed the needs of adults or the needs of persons with severe and profound mental retardation. Moreover, there were no courses that dealt with persons who were developmentally disabled but not mentally retarded. This study also documented that the distribution of educational resources was uneven. Metropolitan areas had significantly higher numbers of qualified staff working in community agencies. Future development should build upon the existing training facilities which are located in each region of the state.

Policy Analysis Paper No. 14: Training Needs as Perceived by Residential and Day Program Administrators and Staff. (1983, April 13). This paper summarized the findings of a survey of residential and day program managers and direct care staff who work in community facilities serving persons with developmental disabilities. Sample personnel policies, job descriptions, job applications, and performance review forms were also collected and analyzed. The sample documents revealed the need for training of managers. A statewide random sample of 312 direct care staff members indicated need for preventing behavior problems, designing and developing behavior management programs, and current information on handicapping conditions.

Policy Analysis Paper No. 15: An Update to Policy Analysis Series No. 4: Cost Function Analysis of Minnesota Intermediate Care Facilities for Mentally Retarded (ICF-MR) Per Diems:1980. (1983, March). This analysis used data from 1980 and was an update to the earlier cost-function analysis reported in *Policy Analysis Paper No. 4*. The study of costs was seen as important for several reasons: (a) the mandate under the *Welsch* Consent Decree to reduce the number of people with mental retardation living in state hospitals; (b) the continued increase in the number of community-based ICFs-MR;(c) the "double-funding" dilemma of maintaining both a state hospital system and a community-based system of services; and (d) the emergence of alternative, cost-efficient models of residential care such as specialized adult foster care, semi-independent living services, and family subsidy and support programs.

According to this study, most people living in community ICFs-MR resided in larger facilities. Although the largest facilities accounted for only 4.1 percent of the total number of facilities, they accounted for nearly 1 out of every 4 community ICFs-MR beds. A major portion (71.2 percent) of the total operating budgets in 1981 was related to personnel costs. In the regression analysis for facilities serving more than 12 people (ranging from 13 to 171 residents), the equation accounted for 89.1 percent of the variation in per diems. Eight of the twenty variables analyzed were statistically significant: system capacity, staff-resident ratio, years of operation, behavior problems, consultant contracts, occupancy rate, direct care staff (full-time equivalent), and Class A/Class B licensure. The paper concluded that although cost

factors were important, other factors must also be considered such as normalization principles, appropriateness of services, and the provision of least restrictive environments.

Policy Analysis Paper No. 16: A Statewide Summary of Sheltered Employment Programs. (1983, April 19). This paper presented findings of a survey of 25 sheltered workshops throughout Minnesota during federal fiscal years 1980-1983. The components studied were vocational evaluation, work adjustment training, long-term sheltered work, skill training, work activity, and work. Data on fiscal and programmatic status of the workshops were collected and analyzed. Some of the findings were: (a) sheltered workshops were experiencing lengthy waiting lists for services (such as 807 persons in 1982); (b) there was an overall trend toward service reductions in 1982 because of lack of available work; (c) changes in average daily attendance varied according to the type of sheltered employment program; and (d) total revenues for 1982 increased 5.2 percent over 1981 to a total of $35,746,058.

Policy Analysis Paper No. 17: An Update to Policy Analysis Series No. 6 through 9: The Financial, Client, and Program Status of Minnesota Developmental Achievement Centers: 1982. (1983, March 28). This paper presented findings of the 1982 survey of 107 Developmental Achievement Centers (DACs) in Minnesota. Some of the major findings included: (a) the statewide total revenues for DACs increased 5.5 percent over 1981; (b) 31 percent of the centers reported operating deficits for 1982; (c) 44.5 percent of the DAC clients lived in natural or adoptive homes, 43.3 percent lived in community group homes; (d) 402 persons were on waiting lists at 28 of the centers; (e) 528 adults were reported to be ready for work placement but were unable to move to such placements because of lack of available work stations, reluctance on the part of parents or the clients, client characteristics, or lack of community support services.

Policy Analysis Paper No. 18: The Minnesota Family Subsidy Program: Its Effect on Families with a Developmentally Disabled Child. (1983, May 2). Beginning in 1976, this subsidy program has provided grants to families up to $250 per month per family to purchase support services. Priority has been given to families with children who have severe and multiple disabilities. Findings of the study revealed: (a) 97 percent of the families responded that the program was of great help to them; (b) the subsidies helped families to keep their child at home rather than to seek placement in state or community residential facilities; (c) families were better able to function and cope (financially, socially, and psychologically); and (d) such services can be a cost-effective and a humane alternative to institutional care.

Policy Analysis Paper No. 19: An Update to Policy Analysis Series No. 4 and 15: Cost Function Analysis of Minnesota Intermediate Care Facilities for Mentally Retarded (ICF-MR) Per Diems: 1981. (1983, August 15). This paper presented the findings of a study of Minnesota community-based ICF-MR per diem costs. The study used 1981 data from the Departments of Health and Welfare to identify factors that could explain differences in per diem rates found among ICF-MR facilities. This study updated the work completed in Policy Analysis Papers Numbers 4 and 15. One-way analysis of the data found significant differences in per diems as a result of location, size of facility, staff-resident ratio, class of facility (A or B), years facility has been in operation, ages of residents, degree of disability of the residents, and level of dependency of the residents. Multiple regression

techniques tended to support the one-way analyses. The research showed that the importance of certain variables changed from previous years; however, the policy issues raised in *Policy Analysis Paper Number 15* remained relevant.

Policy Analysis Paper No. 20: Respite Care: A Supportive and Preventive Service for Families. (1983, October 18). This paper summarized literature relating to respite care and identified available resources which Minnesota could draw upon when planning and implementing future support services to families. Respite care services were described as supportive to families and a means of forestalling out-of-home placement. In Minnesota, there had been an over-reliance on the use of state hospital facilities by families seeking temporary relief because respite care services were not available in most communities. Several key elements were listed for developing respite care as an ongoing social service in Minnesota.

Policy Analysis Paper No. 21: Summary and Analysis of Minnesota Developmental Disabilities Respite Care Demonstration Projects (Federal Fiscal Years 1981-1983). (1983, October 24). This continuation of *Policy Analysis Paper No. 20* presented a summary and analysis of 16 respite care demonstration projects that were funded by the Minnesota Governor's Planning Council on Developmental Disabilities over a three-year period. Securing a stable funding base was seen as essential to establishing dependable respite care services in Minnesota.

Policy Analysis Paper No. 22: Improving the Quality of Life for People with Disabilities: Potential Uses of Technology. (1984, April). This paper summarized literature relating to the expanding utilization of technology for persons with developmental disabilities. Some major findings were: (a) modern technology can improve the quality of life for persons with disabilities in the areas of communication, mobility, independent living, education, and employment; (b) technology is difficult to obtain because of inadequate funding; (c) people who need technological aids should have access to adequate assessment, prescriptions, and follow-up services; and (d) a state policy agenda for use of technology by people with disabilities in Minnesota should be developed and implemented.

Policy Analysis Paper No. 23: The Financial, Client, and Program Status of Minnesota Developmental Achievement Centers: 1980-1984: An Update to Policy Analysis Series No. 6-9 and 17. (1987, January 2). This paper examined the data and trends in the provision of services by Developmental Achievement Centers (DACs) to persons with developmental disabilities from 1980 to 1984. Trend analysis techniques were performed on selected financial and program items. Total revenue rose from $22,890,077 in 1980 to $35,567,043 in 1984, an increase of 55.4 percent. Government provided 93 percent of the total revenue. Expenditures rose by 52.7 percent over the same five-year period. Over a ten-year period (1973-1984), revenues had increased from $5.3 million to $35.6 million serving 3,125 persons in 1973 and 6,105 persons in 1984. Average per diem rates rose by 26.7 percent between 1981 and 1984—from $19.32 in 1980 to $24.45 in 1984. Adult enrollment tripled—from 1,500 to 4,500. In 1984, of the 4,473 adults enrolled in DACs, 2,626 (58.7 percent) lived in Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR), while 1,111 (24.8 percent) lived in their natural or adoptive home. Only 103 of the adults enrolled in DACs lived in semi-independent or independent living settings. Most of the population served (64 percent) had mild, moderate, and severe levels of mental retardation. Waiting lists ranged between 368 and 449 persons during this five-year period, with an anticipation that more people would be needing DAC services because of the Federal Court mandate under the *Welsch* Consent Decree to reduce the number of persons with mental retardation in Regional Treatment Centers to 1,850 by mid-1987.

Policy Analysis Paper No. 24: Minnesota Case Management Study/Executive Summary (1988, February). This paper summarized a study conducted by the Minnesota University Affiliated Program on Persons with Developmental Disabilities under a contract with the Governor's Planning Council on Developmental Disabilities, State Planning Agency. The study identified significant barriers to the provision of effective case management services for persons with developmental disabilities and their families. At the time of the study, there were 290 case managers serving an estimated 15,000 persons with developmental disabilities in Minnesota. The amount of paperwork, heavy client caseload, inadequate training, staff shortages, insufficient funds, and the large number of required meetings were some of the common barriers identified in the study. Questionnaires were sent to county case managers, case manager supervisors, and county human service agency directors. Recommendations for improving the case management system included: (a) that the state of Minnesota apply for Medical Assistance funding under the Consolidated Omnibus Reconciliation Act to gain more funding for case management services; (b) that a 1:30 caseload ratio be attained which would require an additional 210 case managers with an additional $7,350,000 to be added to the existing budget for the Department of Human Services budget; (c) that the Data Integration Projects of Dakota and Itasca Counties, innovative projects funded by the Governor's Planning Council on Developmental Disabilities, a computer-assisted program, held promise for decreasing time spent on paperwork by case managers and increasing time devoted to clients and their needs; (d) that cross-agency cooperation is needed to improve preservice training programs to eliminate the necessity of case managers receiving a fragmented education after employment; and (e) that in-service training for case managers be coordinated so that workshops will be offered on a consistent basis and, over time, will present comprehensive philosophy, information, and skills development for case managers in the field.

Policy Analysis Paper No. 25: Minnesota Developmental Achievement Centers: An Update to *Welsch* Policy Analysis Papers No. 6-9, 17, and 23. (1988, February). This paper reported the results of the data collected from Developmental Achievement Centers (DACs) for the year ending December 31, 1986. This study was conducted under a contract with the Minnesota Supported Employment Project. In addition to the types of data collected from the DACs in previous years, this study introduced an individualized tracking system, and collected information relating to supported employment as DACs began to convert over to providing such services.

In 1986, 4,883 adults and 1,522 children were served by the DACs. The child population decreased from 1,632 in 1984, a decline which reflected a shifting of children's services to the public school system. Nine DACs had discontinued services to children, and twelve to fifteen additional centers indicated such a likelihood during the coming year. Close to 40 percent (N = 602) of the 1,522 children served were between birth and 2 years old. About one-third of the adult population had severe mental retardation. One-fourth of the adult population had mental retardation and additional disabilities such as severe behavior problems, hearing impairments, blindness, epilepsy, cerebral palsy, and other physical disabilities. More than 60 percent of the adults enrolled in DACs lived in ICFs-MR, indicating an increasing trend from previous years.

While 3,498 adults (71.6 percent of all adults) worked on vocational activities within the centers (earning an average of $0.68 per hour), there were only 988 (20.2 percent) active in community-based vocational activities outside the DAC facilities, earning an average of $1.99 per hour. DAC revenues increased by $2,226,755 from 1985 to 1986 and by $6,899,564 from 1984 to 1986. Total revenue for the DACs in 1986 was $42,466,608. Medical Assistance dollars continued to grow and was becoming the primary source of reimbursement of DAC services.

Policy Analysis Paper No. 26: Supported Employment: Review of the Literature. (1989, March 31). The purpose of this paper was to summarize a review of the literature on supported employment. Four common features were identified among several definitions of supported employment: (a) it takes place in nonsegregated settings; (b) it involves meaningful work; (c) it requires ongoing support and services for maintaining employment; and (d) it allows opportunities to interact socially with individuals without disabilities. Several approaches to providing supported employment were described and analyzed: individual job placements, enclave, mobile crew, and benchwork. An extensive comparison of the organizational and procedural characteristics between these models were analyzed by Mank, Rhodes, and Bellamy (1986). Barriers identified in providing supported employment were: attitudes, job performance, cost, unstable funding mechanisms, reduction in benefits, and availability of jobs. Barriers could be overcome by providing: strong family and advocacy support; outcome-oriented services which foster independence, productivity, integration into the community; resources restructured to meet costs; federal initiatives supported to remove disincentives; and aggressive and creative encounters with community members to bring about employment options. Successful approaches were outlined by Bellamy (1987): (a) focus on tangible outcomes; (b) build slowly and on strengths; (c) maintain a clear employment strategy; and (d) plan for competition between business and service needs.

Policy Analysis Paper No. 27: Supported Employment: Review of Grant Recipients and 1986 DAC Data. (1989, March 31). As a sequel to Policy Analysis Paper No. 26, which contained a review of the literature about supported employment, this paper reported data about community-based employment for persons with developmental disabilities in Minnesota. Information was collected and analyzed regarding: (a) the results of a three-year grant program on supported employment, which was a priority activity of the Governor's Planning Council on Developmental Disabilities from 1984 through 1986; and (b) the results of a survey of the Minnesota day training and habilitation centers in 1986.

In 1984, there were five grants awarded to agencies which placed 113 persons into community-based jobs (i.e., work performed outside of traditional day settings). In 1985, the number of grants increased to nine resulting in 266 supported employment placements. The number of grants increased to 12 in 1986, with 469 community-based work placements. The total earnings in 1985 by 206 persons was $66,230.66, or $321.50 per person. In 1986, total earnings by 355 workers amounted to $369,394.33, or $1,040.54 per person. The leading type of work was maintenance, janitorial, custodian, and cleaning.

The 1986 survey of the 82 day training and habilitation centers revealed that 64 centers had at least one person placed in community-based employment. Only 14 of these centers were providing "supported employment" according to the federal definition. Of the 3,783 persons being served by day training and habilitation centers, 799 worked in community-based employment, 50 of whom met the definition of supported employment. During the last quarter of 1986, these individuals worked a total of 58,116 hours, generating over $121,136 in earnings. Also, 544 (68 percent) were in integrated settings. The two leading types of activities worked by persons from day training and habilitation centers were general cleaning/custodial and outdoor seasonal activities. Considerable differences were noted between programs located in the Twin Cities and nonmetropolitan programs. Workers in nonmetropolitan areas were more likely to: (a) spend more time working within the day habilitation and training center, (b) work fewer hours in community-based settings, and (c) have jobs which were most likely to involve cleaning, janitorial, and seasonal work.

Policy Analysis Paper No. 28: Minnesota Developmental Achievement Centers: 1987 Survey Results. (1989, May). This paper reports the results of data collected from the Developmental Achievement Centers (DACs) in Minnesota for the year ending December 31, 1987. The survey, conducted in cooperation with the Department of Human Services, continued the data collection process begun in 1986, collecting information about vocational activities and supported employment.

Programs for children in DACs continued to decline because of 1986 legislation. This legislation authorized public schools to provide services to children with disabilities starting at birth. Although such services by the public schools would not become mandatory until July 1, 1988, there were 1,054 children (birth to age 5) served by the DACs in 1987, a decrease of 469 children from the previous year. Six programs for children had been discontinued since 1986. Twenty-one additional centers planned to discontinue services provided to children by September 1, 1988, which would result in only three programs for children remaining, all located in the Twin Cities metropolitan area. Decline in services provided to children in DACs resulted in 116 staff layoffs in 1987 and a decrease in revenue—from $10.1 million in 1985 to $7.9 million in 1987.

There were 5,214 adults served by the DACs in 1987, an increase of 341 persons from the previous year. There were 489 new admissions, most of whom had previously attended public schools (27.4 percent), another DAC (21.0 percent), or had recently been served in a Regional Treatment Center (22.7 percent). The majority of adults (54 percent) had moderate and severe levels of mental retardation. Many adults had additional disabilities such as severe behavior problems (18.5 percent of the adult population), epilepsy (16.3 percent), cerebral palsy (10.8 percent), other physical disabilities (10.4 percent), chronic medical conditions (8.5 percent), and mental illness (6.0 percent). There were fewer DAC participants living in Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR), which may have been due to closure of such facilities and increasing number of people receiving services under the Home and Community-Based Waiver Program. Although greater numbers of adults were involved in vocational activities (76.6 percent in incenter, 25.3 percent community-based, and 2.1 percent in supported employment), fewer people were working in integrated settings as compared to the previous year.

DAC revenues increased by $3.2 million since 1986, with Medical Assistance accounting for 39.2 percent of the increase. The total expenditures in 1987 amounted to $44,468,050, an increase of $10.1 million (28.5 percent) since 1984, and an increase of $22.8 million (100.0 percent) since 1980. Total per diem rates for program and transportation increased from $31.69 in 1986 to $34.19 in 1987.

7.2.3
Briefing Books for Minnesota Policymakers

Developmental Disabilities and Public Policy: A Review for Policymakers. (1983, January). This publication was written in cooperation with the Center for Educational Policy Studies, College of Education, University of Minnesota. This publication provided information about persons with developmental disabilities, about trends in community services, and about policy issues and alternatives for the 1980s. Support for the policy goal of normalization was recommended. Furthermore, the state should move toward a consumer-powered system which starts with the individual's needs and strengths, identifies the resources needed, and evaluates the system according to the individual's progress. Funds should be directed toward services rather than facilities, and individuals would not be forced to move as they became more independent or as their needs changed.

Toward a Developmental Disabilities Policy Agenda: Assuring Futures of Quality. (1984, March). This publication stressed that people with disabilities should live, learn, work, and participate with other citizens who are nondisabled. Components identified as essential for achieving several goals included: a statewide prevention and early intervention system; services to support families; special education which would prepare students for independent living; community integration and opportunities for competitive employment; an array of community residential alternatives which would be flexible and responsive to individual needs; and access to technology which could improve the quality of life of persons with developmental disabilities.

Mandate for Action: Recommendations of the Governor's Mental Health Commission. (1986, February 3). The Governor's Commission on Mental Health was formed on June 14, 1985, by Governor Rudy Perpich. The Minnesota State Planning Agency was called upon to provide technical assistance and staff support to the Commission as its members looked at several aspects of mental illness and issues related to mental health services and policies. While some positive trends and exemplary services were highlighted, the Commission noted that the mental health "system" was, "to a significant extent, divided, inconsistent, uncoordinated, undirected, unaccountable, and without a unified direction." Vigorous case management, individual service planning, and uniform placement criteria were absent. Recommendations were organized according to three themes: making a commitment, organizing to meet the commitment, and ensuring that the commitment was met. Immediate steps included: (a) the adoption of a mission statement in state statute; (b) the extension of the Bill of Rights to outpatient mental health services in state statute; (c) the creation in state government of a visible, responsible, and committed focal point of administrative and professional leadership; and (d) the continuation of a Governor's Commission on Mental Health to monitor and advocate the implementation of the recommendations contained in the report.

A **New Way of Thinking.**[1] (1987, January). This policy briefing book was the result of a cooperative effort between the Governor's Planning Council on Developmental Disabilities, State Planning Agency, and the Center for Educational Policy Studies, College of Education, University of Minnesota. This publication provided a summary of what has been learned about people with developmental disabilities over the past few decades, where we are with respect to addressing their basic needs, and a philosophical framework for future directions—toward a new vision of how all people, regardless of having a disability, can be supported in communities. There were three messages:

- There is a new way of thinking about how, where, and with whom people with developmental disabilities can live, learn, and work. It involves a concentration on supporting participation, building on capabilities, adapting environments, and building relationships. Where in the past there were limited options to persons with developmental disabilities and their families, the new way of thinking means assisting individuals and families in identifying what is important to them, and empowering them with decision making and with funding to act upon those choices.
- New service strategies must be explored and new ways of thinking and acting must be experienced. Examples were provided of new service models currently being demonstrated in Minnesota, from supported employment and the provision of options in community living to ways in which the quality of programs can be evaluated by those who use the services.
- The impact of these developments in new policies and services has not yet tipped the balance in the life experiences of people with developmental disabilities and there is still a long way to go. There are great disparities between what we know and what we actually practice, such as early intervention, school integration, and family support services.

The translation of this new vision into reality will depend upon two changes: (a) major reforms in federal funding to encourage the routine and systematic development of services and supports to individuals as participating and contributing members of their communities; and (b) systematic attention at the state, local, family, and individual levels to ensure that the vision of communities that are inclusive rather than exclusive is achieved.

7.2.4
Audiovisual Productions

The following videotapes have been produced, or coproduced, by the Minnesota Governor's Planning Council on Developmental Disabilities and are available on a loan basis through a Lending Library operated by the Council:

Another Perfect Day. (1985). This is a parody on the human services system. Minnesota Governor's Planning Council on Developmental Disabilities. St. Paul: Author.

Clarence J. Sundram: Can We Prevent Abuse and Neglect in Human Services? (1988). Minnesota Governor's Planning Council on Developmental Disabilities. St. Paul: Author.

Gunnar Dybwad: Breaking Down Barriers to Integration. (1987). Minnesota Governor's Planning Council on Developmental Disabilities. St. Paul: Author.

Gunnar and Rosemary Dybwad: International Disabilities Issues. (1987). Minnesota Governor's Planning Council on Developmental Disabilities. St. Paul: Author.

(An) Interview with Betty Hubbard. (1987). Minnesota University Affiliated Program, University of Minnesota. St. Paul: Minnesota Governor's Planning Council on Developmental Disabilities.

(An) Interview with Gunnar and Rosemary Dybwad. (1987). Minnesota University Affiliated Program, University of Minnesota. St. Paul: Minnesota Governor's Planning Council on Developmental Disabilities.

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(A) New Way of Thinking.[1] Minnesota Governor's Planning Council on Developmental Disabilities and Minnesota University Affiliated Program. St. Paul: Authors, 1987.

Tools for Life: How Technology Helps People with Disabilities. Produced by Kittleson & Leadholm for the Minnesota Governor's Planning Council on Developmental Disabilities and the Minnesota University Affiliated Program. St. Paul: Authors, 1988.

7.2.5
Quality Assurance Publications

Guidelines for Quality Individual Plans. (1987, July). This brochure serves as a guideline to assist families and individuals with disabilities to assess whether the written individual plan meets state-of-the-art criteria. Criteria include age-appropriateness, community referenced, functional, generalized, and consideration of individual preferences and choices.

Read My Lips: It's My Choice. . ., by William T. Allen, published by the Minnesota Governor's Planning Council on Developmental Disabilities. (June 1989). This guide covers five ways to help increase the freedom of choice for people with developmental disabilities: assessing needs, planning for services, evaluating services, understanding the service system, and promoting self-advocacy. As the author explains, "It is hoped that the information in this guide is written in a way that is easy to understand. This was done for several reasons: (a) so that people with developmental disabilities who read, can read it and use it; (b) so that people who advocate for those who cannot read can explain it more easily; and (c) so that we can all understand something together." The content focuses not only on helping people with developmental disabilities to become more involved in the decisions which affect their lives but also on how to foster self-advocacy skills—people speaking up for their own rights in their own individual ways.

[1]A New Way of Thinking (videotape) has received recognition through two national awards: (1) the Media Award by The Association for Persons with Severe Handicaps (TASH), December 1988; and (2) the Gold Apple Award by the National Education Association Film and Video Festival, May 1988.

Test Your School's IQ: Integration Quotient: Questions to Ask about Your School's Policies and Practices. (1987, July). This brochure provides questions that are designed to assist families of students with disabilities to assess the level of integration efforts by local school districts and special education cooperatives. This assessment includes administrative commitment, location and transportation issues, and integrated time and activities.

Test Your IQ: Integration Quotient: For Organizations Serving People with Developmental Disabilities. (1988). This brochure provides questions that people might ask organizations about their practices and policies which promote or discourage integration of persons with disabilities. The questions are designed to assist families of persons with developmental disabilities to determine the level of integration efforts provided by the programs and services they use.

7.2.6
Studies and Reports Related to Minnesota State Schools/Academies for Persons Who Are Blind and/or Deaf

The Impact of Closure of the Minnesota School for the Deaf and Minnesota Braille and Sight Saving School from the Perspectives of Students, Families, and Local Schools. (1985, February 8). On January 3, 1985, Governor Rudy Perpich made a preliminary recommendation to close the Minnesota School of the Deaf and the Braille and Sight Saving School located in Faribault. By mid-February, after considerable response from legislators, parents, teachers, and students (including a demonstration in the Capitol Rotunda), the Governor withdrew his recommendation.

The analysis in this report consisted of: (a) a review of every student record; (b) a survey of students; (c) a survey of parents; and (d) a survey of home district special education directors. The surveys of students and families documented universal opposition to the proposed closure. Many students would have considered out-of-state residential schools in the event of closure. Local special education directors expressed concern about closure without following due process procedures. In the event of closure, the local directors preferred placement in the home districts followed by placement in another district. The residential schools in Faribault were described by the respondents in terms of educational quality, opportunity for socialization, involvement in extracurricular activities, and an environment conducive to total communication.

Summary of Reports Prepared for the Minnesota Legislature Regarding Academies for the Deaf and Blind. (1986, February 3). The 1985 Legislature passed legislation requiring the State Planning Agency to direct a study in cooperation with the departments of Administration, Education, Employee Relations, and Finance. The study topics included: (a) management organization structure; (b) governance; (c) financing methods; (d) staff/student ratios; (e) student assessments; (f) admission and discharge (entrance and exit) criteria; and (g) individual education plans. These documents summarized the results of several reports prepared to address these areas. The citations for these documents are as follows:

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For additional information or copies of this plan, contact:
Minnesota Governor's Planning Council
on Developmental Disabilities
STATE PLANNING AGENCY
300 Centennial Office Building
658 Cedar Street
St. Paul, MN 55155
612/296-4018
612/296-9962 TDD

Design and Production: Destiny 2, Inc., St. Paul, MN
Photography: Ann Marsden, Minneapolis, MN